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ABSTRACT

This manual was developed to help instructors train police and emergency medical technicians, who often are the first persons to arrive at the scene of a death (first responders), to serve families who lose a child to Sudden Infant Death Syndrome (SIDS). The manual begins with an introduction that discusses the purpose of the training and overviews the course. Next, lesson plans for a care course and two subunits are presented and each plan, in a three-column format, includes the following: the suggested time allotment for each part of the course, descriptions of instructional events and course content, and questions or problems for student discussion. The one-and-one-half-hour core course, focusing on basic content (e.g., possible parental reactions and responsibilities of the first responder), includes a handout, a film, and case studies. The two one-hour subunits, on, respectively, the participation of SIDS parent and SIDS versus child abuse and neglect, include some or all of the following: guest speakers suggestions, a handout, lecture, class discussion, and case study. A discussion on administering the course concludes this instructor's manual. The appendix, comprising two-thirds of this document, includes the following: handouts, case studies, film content, a list of 1978 SIDS information and counseling projects, and a bibliography. (EM)

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TRAINING EMERGENCY RESPONDERS:
SUDDEN INFANT DEATH SYNDROME
An Instructor's Manual

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Health Services Administration
Bureau of Community Health Services
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U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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A field test of the SIDS Training Manual was conducted as part of an ongoing Emergency Medical Technician-Paramedic (EMT-P) course offered by Emergency Medical Services (EMS) of Armstrong County, Pennsylvania. Mr. Gary W. Fulton, Associate Director/Paramedic Coordinator, Armstrong County EMS, served as the course instructor. Organizations whose members most actively participated in the course include: Ford City Volunteer Fire Department, Kittanning Hose Company, No.6 Ambulance, Lower Kiski Ambulance Service, Inc., and Freeport Volunteer Fire Department-Ambulance.

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INTRODUCTION

Purpose of the Training

This training has been developed for police and emergency medical technicians, who often are the first persons to arrive at the scene of a death (first responders), to serve families who lose a child to Sudden Infant Death Syndrome (SIDS).

First responders answering a call involving SIDS must cope with a bewildering and traumatic episode that may develop into a shattering experience unless competently and confidently handled.

It is recognized that some consequent problems of a SIDS episode could be reduced if first responders were sufficiently aware of SIDS and cognizant of the effect their actions might have on grief-stricken parents at a particularly vulnerable moment. Effective widespread training of first responders could increase their concern and awareness and help them in service to parents of SIDS victims.

The purpose of this training course is to give first responders basic knowledge about SIDS and to sensitize them to the needs and responses of SIDS families. The core and expanded curricula of this course are directed toward achieving the following goals:

1. Help trainee to recognize any unexplainable infant death as possible SIDS incident.

2. Sensitize trainee to the parents' feelings at the time of their contact--bereavement, guilt, blame, hysteria, extreme agitation ("Do something!"), shock, abuse ("Don't you know your job?").

3. Instruct or have trainee practice appropriate actions and attitudes for dealing with various emotional states of parents in a crisis situation.

4. Alert trainee to the kinds of questions he/she might be asked and how he/she should respond if SIDS is indicated.

5. Instruct trainee in what information to collect and how to collect it through observation and sensitive questioning without further upsetting parents. This includes helping trainee distinguish between signs of child abuse and neglect and SIDS.

6. Primarily, insure that trainee recognizes that in a SIDS incident, the survivors become the patients, requiring care and concern for their immediate emotional, and possible physical, health. Subtle verbal and non-verbal actions on the part of emergency personnel can either intensify or mollify the parents' feelings, and have an effect on immediate, as well as long term, reactions to the crisis.

Overview of the Course

The SIDS training course is designed to be presented in a core unit, with opportunity for expanded training. It can be used as part of an existing training program for first responders, or it can be offered independently as a seminar on SIDS. The core unit of the SIDS training course is limited to approximately one-and-one-half (1-1/2) hours. Two additional subunits, approximately one hour each, can be used separately or together to provide for in-depth coverage of the topic. The core curriculum consists of the following components:

1. Handout (found in Appendix A)

   The handout is to be read prior to the classroom period, if practical. By doing this, students will be equipped with a framework of knowledge upon which they can build in the classroom. If it is not possible for the handout to be read prior to the classroom session, allow about 15 minutes at the beginning of the course for the students to read the text and answer the study questions. This will slightly modify the scheduling time. Topics covered in the handout are:

   - Definition and incidence of SIDS
   - Clinical history and findings
   - Determining SIDS victims
   - Role of first responder (this has been customized to meet the needs of two groups - police officers and emergency medical technicians)
   - Parental reactions

2. A 16mm film, A Call for Help

   This film portrays the roles of police officers as first responders, though the sensitive handling of the SIDS parents is applicable to any groups of first responders. The running time of this film is 19 minutes.

3. Case Studies (found in Appendix B)

   These case studies are designed to be used in a group discussion to focus learning on concrete problems from real life and to encourage active participation of all students. The cases also provide opportunities for trainees to explore alternative means of dealing with SIDS episodes.

The expanded curricula consists of two subunits:

Subunit 1. Participation of SIDS Parents

Subunit 2. SIDS versus Child Abuse and Neglect

Since the participation of a SIDS parent in a group discussion has proven effective, Subunit 1 has been developed for instances when parents are available and willing to share their experiences. Included in this manual are organizations to contact to obtain speakers for this session. The amount of time devoted to this subunit should be discretionary, but one to two hours should be planned.

Because of the potential for mistaking a SIDS episode for child abuse and neglect, Subunit 2 has been developed around this theme. A handout which compares SIDS with child abuse and neglect will be the basis of the group discussion for this subunit. It is recommended that a local authority, such as a pathologist, medical examiner, or pediatrician be contacted to serve as guest speaker on the topic.

PREPARING FOR THE COURSE

Tailoring the Course Materials

This training package has been designed to be flexible in that it can be tailored to meet students' needs and interests. Although the basic course requires a minimum of one-and-one-half (1-1/2) hours to

complete, the tailored course may require additional time. Subunits may be added or the basic course extended for any of the following reasons:

- Student interest indicates that more discussion time is necessary, thus perhaps expanding the basic course to two hours.
- Student interest at end of basic course is such that there is a desire to schedule one or both of the additional subunits.
- Local legal obligations of the first responder, which are applicable to the SIDS situation, may be added and discussed.
- The need for specific types of training in your community (e.g., high frequency of child abuse incidents) may indicate course expansion.
- Coffee breaks or other rest periods will need to be provided if more than one subunit is given in sequence.
- Time may need to be added for administrative matters such as making announcements or taking attendance.

If you are unable to obtain a copy of the film, A Call for Help, you can tailor the course by substituting a mini-lecture and discussion session for film. It is recommended that you prepare your lecture using the Content Outline of the Film, Appendix D, and the handouts. You should also try to obtain some additional literature on SIDS to familiarize yourself with the subject matter. Several acquisition sources (AS) for SIDS materials are listed in the Bibliography, Appendix F. The five major topics found in the Outline (Roman numerals I to V) should be the building blocks for your mini-lecture. Although it would be most effective for you to formulate your own discussion questions based on your lecture, you may wish to use the idea of generating lists as in letter D, number 4, under the Film heading in the Lesson Plans. Since the mini-lecture and discussion will not be as effective as the film, A Call for Help, every effort should be made to obtain the film. Instructional events for this modification are found on page 11 of this manual.

Using the Lesson Plans

The lesson plans present a structure which guides the instructor through the process of teaching the content to be learned as stated in the objectives. They should be carefully studied well in advance of the

course offering in order to allow sufficient time to prepare all materials and to become thoroughly knowledgeable about the content. In general, the lesson plans call for two main steps. First, briefly review the objectives, thus setting the goals and standards for successful completion of the course. Second, teach the skills or knowledges as indicated by the lesson plans.

The objectives of this course can be met, though the instructor is not a SIDS expert. However, since this course is built around group discussion, and questions and answers, it may be necessary that the instructor be able to field questions and guide discussions beyond what is outlined in the lesson plans. It is, therefore, recommended that the instructor read additional materials on SIDS. Several such articles are found in the Bibliography of this manual, (Appendix F). To take the course even a step further, the instructor may consider having a SIDS expert attend the course to serve as a resource person. Such a person may be contacted through the parents' groups or SIDS Information and Counseling Projects, (see page 27).

A three-column format is used for the lesson plans. The center column contains information organized to structure the instructor's activities along lines that adhere to pedagogical principles. It contains the following kinds of information:

- Descriptions of the instructional events in the order in which they should occur for most effective learning.

- Suggestions for what the students should be told in order to clarify certain issues. The instructor, however, should not read the text exactly as written. Rather, he/she should paraphrase the ideas contained in the text.

- Questions or problems that may be posed for student discussion.

The right-hand column identifies points at which instructional aids and resources should be used. It can also be used for notes by the instructor.

The left-hand column indicates the suggested amount of time to be spent on each part of the course so that the instructor can pace himself/herself. These times are only estimates and the instructor need not strictly adhere to them.

Guidance for administering the course follows the lesson plans.

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
0:00	Introduction A. Welcome students. B. Give your name. C. Have students introduce themselves and, if applicable, identify the unit they represent. D. Make any necessary announcements, (e.g., scheduled times of subunits). E. Go over purpose of the course. 1. To give first responders basic knowledge about SIDS and to help them to recognize any unexplainable infant death as a possible SIDS incident. 2. To sensitize trainee to the parents' feelings at the time of their contact-bereavement, guilt, blame, hysteria, extreme agitation ("Do something!"), shock, abuse ("Don't you know your job?"). 3. To alert trainee to the kinds of questions he/she might be asked and how he/she should respond if SIDS is indicated. 4. To instruct trainee in what information to collect and how to collect it through observation and sensitive questioning without further upsetting parents. This includes helping trainee distinguish between signs of child abuse and neglect and SIDS. 5. Primarily, to insure that trainee recognizes that in a SIDS incident, the survivors become the patients, requiring care and concern for their immediate emotional, and possible physical, health. Subtle verbal and non-verbal actions on the part of emergency personnel can either intensify or mollify the parents' feelings, and have an effect on immediate, as well as long-term, reactions to the crisis.	

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
	F. Discuss the training approach. 1. Group instruction - much use of group discussion based on case studies. Questioning encouraged. 2. Instructional media/supplements - group discussion to be supported by and based upon a film and a handout. <u>Handout</u> A. If the trainees have had an opportunity to read over the handout before coming to class, begin the course by asking for questions or comments on the handout. If not, distribute the handout and allow the students time to read it and answer the study questions. After the students complete the task, ask for questions or comments on the handout. B. Go over the answers to the self-study question with the class and discuss any problems or conflicts. If there is much student discussion on SIDS versus Child Abuse, you may wish to distribute the Subunit Two handout to provide the students with more facts. C. Stress to the students the fact that SIDS can <u>only</u> be diagnosed by an autopsy, and that alert first responders can suspect a possible SIDS victim, and act accordingly. Students should not feel that they can diagnose SIDS, or that they can indicate SIDS as the cause of death to the family. D. Discuss any of your notes or comments on the handout.	Copy of Handout, with your notes. Sufficient copies of Handout, <u>Appendix C</u>.
0:10	<u>Film</u> A. Give a brief introduction to the film. If the students are not police officers, stress that the sensitive manner with which the depicted officers handle the situation is applicable to any group.	Film: <u>A Call for Help</u>, and a 16mm projector

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
	B. Suggest that the students pay attention to:	
	1. Treatment of SIDS family at home and in the hospital.	
	2. Parental reactions.	
	3. Methods of obtaining information.	
0:15	C. Set up and present the film.	
0:35	D. After viewing the film, A Call for Help:	
	1. Encourage questions or comments from the students.	
	2. It must be pointed out that the resuscitative procedures illustrated contain technical errors.	
	a. Back blows delivered at inappropriate time.	
	b. When performing infant cardiopulmonary resuscitation, must do compressions as well as ventilations.	
	3. Briefly review basic resuscitative procedures as found in the handout. Note to the students that infant CPR requires special training and, in some cases, certification. If any of the students are not trained in this area, they should not consider this as a training session, and should not attempt to perform infant CPR. They are to respond within the realm of their capabilities.	Figure 1 in Handout.
0:40	4. The following are topics of discussion based on the film and handout for the trainees. On the chalkboard or flip chart write the main subject headings (found after the following letters "a," "b," "c," and "d") for discussion. Note that the heading after letter "a" contains three parts (Home, En route, and At hospital).	Outline Appendix D. Chalkboard or Flip Chart.

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
	This should be written so that each part can be discussed individually. To start the discussion, ask the trainees to suggest items for you to write down under each heading. For your convenience, a list of possible topics of discussion is provided for each discussion heading. These lists are not all inclusive, and are not the only answers. a. Proper procedures for treatment of SIDS families in home, en route, and at hospital. 1) Home. a) Parents never left alone. b) Make no assumptions about cause of death. c) Do not pronounce infant dead. d) Make parents feel that something is being done. e) Explain what you are doing, or where infant is being taken. f) Arrange transport of parents to hospital. g) Arrange for care of siblings. 2) En route. a) Continue to be supportive of the parents. b) Encourage them to talk. c) Answer any questions concerning your procedures calmly and professionally. d) Maintain control of your feelings.	

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
	3) At hospital. a) Keep parents informed about child's status. b) Offer to: (1) Make phone calls. (2) Get coffee. c) Sit with parents and provide a sympathetic ear. b. Possible parental emotional reactions: 1) Bereavement. 2) Guilt feelings. 3) Extremes. a) Hysteria. b) Anger. c) Frustration. c. Some possible consequences later suffered by SIDS parents: 1) Life-long feelings of guilt. 2) Depression. 3) More severe. a) Divorce. b) Suicide. c) Alcoholism. 4) Delayed grief.	Refer back to Handout.

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
	d. Proper questioning techniques of SIDS families, including ways of obtaining information which is not naturally forthcoming: 1) Observe scene of SIDS incident. 2) Parents. a) Encourage them to talk. b) Pay attention to what information they volunteer. c) Direct questioning.	Handout.
	OPTIONAL--The Mini-Lecture is to be used only if film, A Call for Help, is unavailable. Mini-Lecture and Discussion	
0:10	A. Present your lecture based on the outline found in Appendix D. Major points to be included are: 1. Treatment of SIDS family at home. 2. Possible parental emotional reactions to be encountered by first responder. 3. How to deal with SIDS survivors. 4. Obtaining information. 5. Treatment of SIDS family at hospital emergency room.	Copy of Appendix D. and your notes.
0:35	B. Bring up for discussion any aspect of dealing with SIDS survivors you feel should be emphasized. or Have students generate lists, as found in letter D, number 4 under Film heading.	 Refer back to p. 8.

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
0:55	Case Studies A. The students will now have an opportunity to focus their learning on various situations set forth in the following case studies. B. You should have the case studies reproduced so the students can follow along as you read, and so they can easily refer back to the material during the discussion. Remember to reproduce enough copies for all the students. C. Read each of the case studies aloud to the class and then discuss them. To help guide the discussion, a series of relevant questions follows. Pose the questions one at a time to the students and briefly discuss. These are not the only questions you should ask. You should look over the case studies and add any additional questions you might think are important. Help generate discussion of the questions by asking the students for alternative answers and for the reasoning behind their answers (e.g., "What else might you do for this problem?" "Why would you do that?"). Answers to the questions are provided for your convenience. It must be stressed, however, that these answers are not the only ones possible. Discussion Questions: Case Study #1 1. You are talking to the mother and taking notes. What should your partner be doing? Checking the condition of the baby, beginning infant resuscitation procedures. 2. What are some of the important facts the mother is telling you that you should write down? Age - 3-1/2 months Sex - Male Baby unresponsive after night's sleep. Cold/Diarrhea On medication	Case Studies #1 and #2, Appendix B. Your copy of Case Study #1, and notes.

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
	3. What might you ask the mother for more information on? Want to find out what type of medication was used and the doctor who prescribed it. Will want to take medication with baby to hospital. 4. What else should you take notes on? Physical condition of house, room, crib. Behavior of mother. Baby's condition, position in crib. Procedures initiated by your partner. 5. What should you do for the mother? Take her from the room--may help her to stop crying. Explain what your partner is doing. Explain that you must take the baby to the hospital. 6. You are on your way out the door with the mother and infant when the phone rings. The woman says, "It must be my husband." What do you do? You should answer the phone. If you don't he might panic. Do not let the mother answer--she's too upset. Explain where you are going and suggest that he meet you there. Keep it brief. You want to get moving. 7. Once at the hospital emergency room, what should you do? Turn over the infant, along with the medication, to the emergency room personnel. Go and sit with the mother, offering your assistance in any way. 8. The father arrives, obviously distressed and confused. What should you do? Begin explaining the facts to him as you know them. Give him the latest information	

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
	concerning the baby's status. If the mother wishes to explain the situation, let her. If your talk with the father begins to upset the mother, take him aside and finish the conversation. Whenever possible, talk to both parents together since suspicions can arise concerning the topics of "private" conversations. 9. What about additional questioning? Wait for the physician to make the pronouncement of death. If SIDS is indicated as possible cause, there is no need for further questioning. 10. Ask for additional questions or comments from the class.	
1:10	<u>Discussion Questions: Case Study #2</u>: 1. What should you be doing during this episode? Checking on the baby's condition, beginning resuscitation procedures, making mental notes about the baby's position and physical appearance. If you wipe the baby's mouth clean, remember to save the article used and give it to the hospital personnel. 2. What should your partner do about the grandmother? First, he/she must maintain control of his/her own feelings. Your partner should take the grandmother into another room and try to calm her down. He/She should explain to the grandmother what is being done and that the baby must be taken to the hospital. 3. Meanwhile, can you conclude that this is a possible SIDS case? If so, why? If not, why not? Yes, you can suspect SIDS because of: a. Baby not responding after nap. b. Baby twisted in blanket. c. Frothy discharge around nose and mouth.	Your copy of Case Study #2, and notes.

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
	4. When the time comes to transport the baby, would you allow the grandmother to come along, or would you suggest that she come to the hospital later with the baby's parents? The grandmother should be taken along with the infant since she is the responsible adult caring for the baby at the time of its death. 5. At the hospital, how should you react toward the grandmother? You would react toward the grandmother as you would any SIDS parent. The abuse exhibited earlier may be her way of reacting to the sudden death of a loved grandchild in her care. She may be transferring the anger she feels toward herself to you. 6a. What about the parents of the child? Find out if they have been notified. If not, offer to notify them for the grandmother. b. If you must notify the parents, what would you tell them? Tell them the facts as you know them. Do not diagnose or pronouce the baby dead. Tell them to what hospital you have taken the baby. Tell them the grandmother is there also. 7. To whom should you address any further questioning? Both the parents and the grandmother, since she was the last person to see the baby alive. 8. Ask for additional questions or comments from the class.	

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
1:25	Conclusion and Summary A. Review major points that have been covered. 1. General facts about SIDS - incidence, etc. 2. Appearance of SIDS babies. 3. Possible parental reactions. 4. Responsibilities of first responder. B. If subunits are scheduled for another date, remind trainees of the date, time, and place.	

SUBUNIT 1

PARTICIPATION OF SIDS PARENT

Speaker's function:

1. To give first-hand account of the feelings of a parent who has lost a child due to SIDS.

2. To give concrete examples of the effect on parents of proper and improper handling by a first responder.

3. To describe the activities of the parents' organization and/or SIDS Counseling Center.

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
0:00	A. Introduce speaker. (During the talk, make notes and formulate questions.)	
0:40	B. Question-and-answer period. (If no questions are forthcoming from the class, start the questioning yourself.)	
0:55	C. Summarize what has been learned about the implications for the role and responsibilities of the first responder.	

SUBUNIT 2

SIDS VERSUS CHILD ABUSE AND NEGLECT

Speaker's function:

1. To give concrete examples of cases in both categories, possibly including some where child abuse and neglect was suspected but autopsy showed SIDS to be cause of death.

2. To answer the trainees' specific questions about medical aspects of SIDS and child abuse and neglect.

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
0:00	A. Go over objectives for this subunit. 1. To improve trainees' skills in distinguishing between SIDS and child abuse and neglect. 2. To sensitize trainees to the possible trauma to parents who are unjustly suspected and/or accused of child abuse and neglect.	
0:05	B. Describe the instructional events that have been scheduled. (In order to allow more flexibility, the remainder of this unit has been divided into modules. Separate times are given for each module--times are approximate. If you have not scheduled a speaker, you will use Modules A, C, and D. If you have scheduled a speaker, you will use Modules A, B, and D.)	
	<u>Module A--Discussion of Handout</u> (Instructor should lead discussion with guest speaker serving as resource person.)	
0:00	A. Distribute handout and allow a few minutes for trainees to read it.	Handout - SIDS Versus Child Abuse and Neglect.
0:05	B. Go over main points of handout. Answer questions and add your own comments.	

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
0:10	C. Discussion Questions 1. If you are the first responder in the sudden death of a child under one year, is it more likely to be SIDS or child abuse and neglect? SIDS, by overwhelming odds. It is very rare to see a death due to child abuse and neglect in this age group. 2. What aspects of a SIDS baby's appearance might lead you to suspect child abuse? Settling of blood (lividity) looks like bruises, blood-tinged froth at nose and mouth, diaper rash may look like a burn. 3. What kind of emotional reaction on the part of a SIDS parent might lead you to suspect child abuse? The parent may be in such a state of shock that he/she displays no emotion, no apparent grief. Or the parent's guilt feelings may lead him/her to say, "I killed my baby. It's all my fault."	
0:25	D. Conclusions Knowledge of the normal reactions of parents and of the "normal" appearance of a SIDS baby will help the first responder avoid unfounded suspicions of child abuse and neglect.	
	Module B--Lecture by Guest Speaker	
0:00	A. Introduce speaker. (During the lecture, make notes and forumulate questions.)	
0:30	B. Question-and-answer period. (If no questions are forthcoming from the class, start the questioning yourself.)	
0:40	(Go directly to Module D.)	

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
	Module C--Mini-Lecture by Instructor (Should be very brief, since focus of course is on SIDS, not child abuse and neglect.)	
0:00	A. Additional clues to child abuse and neglect. 1. Physical appearance of child. - fractures - scars - cigarette burns - marks which show the shape of an instrument imprinted on the skin 2. Physical appearance and behavior of parents. - spouse abuse - vague, evasive - reluctant to volunteer information 3. Physical appearance and behavior of siblings. - apathetic, unresponsive - no crying; or mournful, helpless crying (child does not expect to be comforted) - malnourished - improperly dressed } "neglected look"	
0:05	B. Profile of an abusive parent. 1. Usually socially isolated, may be newcomer to community. 2. Often unable to form close emotional relationships. 3. Probably was abused as a child. 4. May express dislike or resentment of child. 5. May have unrealistic expectations of the child (i.e., expect behavior that is far beyond the child's chronological age). 6. May perceive the child's crying, etc., as a deliberate attempt to annoy the parent.	
0:10	C. Conclusions The parent who abuses a child has emotional problems and needs help.	

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
	Module D--Group Discussion	
0:00	A. Distribute copies of Case Study #3 and read it aloud.	Case Study #3, Appendix B.
	B. Discussion Questions	
	1. How would you feel if you were the parent described here?	
	(Shocked, angry, helpless--added to grief over baby's death.)	
	2. On what basis did the police officer suspect child abuse and/or neglect?	
	(Parent's lack of emotion, vague answers, appearance of baby, other child's broken arm.)	
	3. How should he have handled the situation?	
	(Exactly as you were taught in the basic course--observe, make notes, remain objective, be supportive of parents.)	
	NOTE: Students should be made aware that similar incidents have actually occurred. In one reported case, the parents were in jail at the time of the child's funeral--the autopsy showed that death was due to SIDS.	
0:15	C. Read aloud (or distribute) Case Study #4.	Case Study #4, Appendix B.
	D. Discussion Questions	
	1. It may be harder for you to put yourself in this parent's place, but try to imagine how you would feel.	
	(If parent was fond of child but hit it in anger, he/she would probably feel grief, guilt, remorse, and fear. Even if parent had no emotional attachment to the child, he/she would probably feel fear. The use of "it" instead of "he" or "she" connotes lack of attachment.)	

DETAILED LESSON PLAN

Lapsed Time	Instructional Events	Support Materials/Notes
	2. If you were the first responder on the scene and all the obvious signs of child abuse and neglect were there, what would you do? (Same as in SIDS--wait for autopsy to confirm cause of death. Remember that this parent also needs emotional support.)	
0:30	E. <u>Conclusions</u> 1. Always give parents the benefit of the doubt--assume SIDS until autopsy shows otherwise. 2. Try to maintain objectivity even if evidence of child abuse and neglect is strong. Even if the parent has abused the child in the past, death could still be due to SIDS or to some other cause.	
0:35	F. <u>Review</u> local regulations and procedures for reporting child abuse and neglect, autopsy procedures, etc. (Guest speaker may be a resource person.)	

ADMINISTERING THE COURSE

What to Do in Setting up the Course

Since this course has been developed to serve as a supplement to existing training, or as a seminar on a special topic, the instructor will play dual roles. He/She will be responsible for both administering and instructing the course.

As the course administrator, the instructor will be required to undertake the following tasks:

- Initiate any and all actions required for offering the course.
- Review course content and determine if the core course is to be expanded.
- Identify and secure the services of appropriate resource personnel (e.g., SIDS parent, a pathologist, etc.).
- Identify and enroll students who qualify for the course.
- Schedule class times.
- Identify and secure appropriate training facilities, aids and associated equipment, and reference materials.
- Obtain sufficient training materials for all students.
- Oversee the actual conduct of the course to ensure that it proceeds as planned.

When teaching the course, the instructor must be able to perform the following teaching functions:

- Process Observer. Watch the learning process and use the observations to help examine his/her teaching effectiveness and student progress.
- Standard Setter. Express standards and objectives to make students aware of learning expectations.

- Communicator. Show good communication skills (lecture or group discussion) and make sure that students understand what is being said; listen and serve as an interested audience for students.

- Customizer. Incorporate discussion of local policies, practices, and procedures into the framework established in the lesson plans.

- Process Manager. While delivering the instruction, keep the objectives in clear focus, elicit and stimulate relevant discussions, and develop the content.

- Counselor. Identify sources of difficulties the student has in learning effectively and prescribe appropriate corrective action.

- Instructional Materials Developer. Prepare materials which support instruction.

When the lesson plan calls for discussion, the instructor takes on the responsibilities of discussion leader, which are as follows:

- Introduce the discussion, making sure that the subject is clear and sufficiently limited.

- Keep track of the time and the subject so that the discussion does not get bogged down or sidetracked.

- Restate and call attention to the main points and ideas so that learning is focused.

- Promote a climate of acceptance, openness, and support to facilitate learning and participation in the discussion by all students.

- Know when to end the discussion, and summarize.

Scheduling

The basic one-and-one-half (1-1/2) hour course can be expanded by using one or both subunits of the expanded curricula. These additional subunits can be scheduled together with the basic unit, or separately. For example, the core course can be scheduled one day, and one or both of the expanded subunits, the next week.

When scheduling Subunit 1, "Participation of SIDS Parents," remember that it involves questions and discussion, therefore making it difficult to assign an exact time frame. One or two hours should be allowed for this subunit, and it is suggested that it be scheduled so that discussion carry-over is permitted.

Subunit 2, "SIDS versus Child Abuse and Neglect," should add an additional hour to the course if using only the handout and group discussion. However, if a local authority agrees to serve as a guest speaker on the topic, more time should be provided for the talk and the ensuing questions and discussion. Again, discussion carry-over should be permitted here.

Class Size

Because of the nature of the topic and the fact that the training involves active participation by students in group discussion, it is recommended that class size be about 20 students.

Facilities/Resource Requirements

The facility required for this course should contain a lectern for lesson plans and notes, as well as a projection screen and a chalkboard. The student area should contain enough tables and chairs, or chairs with writing surfaces for note taking, to accommodate at least 20 students. These should be arranged in a "U"-shape or a semicircle to create an atmosphere which is conducive to group discussion. The instructor may choose to sit at the table with the students, and should be seated in a central location within the group. The students should have unobstructed visual access to the instructor's area and the projection screen. For sample seating arrangement plan, see Figure 1. The facility should be well lit, and the light switch should be easily accessible to allow for light dimming during the viewing of the film. Temperature controls should be provided for student and instructor comfort. In addition, there should be access to power sources to operate the necessary 16mm movie projector.

The film required for the course is A Call for Help. It is recommended that the instructor view this film at least once before the classroom session. An expanded outline of the film content is provided in Appendix D of this manual. You may wish to look over this outline as a preview to viewing the film. It can also be used as a reference for discussion after the film has been shown to the trainees. However, it is suggested that the instructor make his/her own notes of points to discuss about film content. Information concerning the film and where it can be obtained is listed below:

A Call for Help. Department of Health, Education, and Welfare; Health Services Administration, 1975. 16mm

motion picture to help emergency workers and first responders understand and help the families of a sudden infant death. 19 minutes, sound, color.

- To purchase the film, write to:

  National Audiovisual Center
  (GSA)
  Washington, DC 20409
  Attention: Order Section

The cost of the film, as of September, 1978, is $110.25. This price is subject to change. When ordering A Call for Help from National Audiovisual Center, you may use its title number: 007899. Allow at least six weeks for your order to be completed.

- To borrow the film, no-charge bookings are made through:

  National Medical Audiovisual Center
  Annex, Station K
  Atlanta, GA 30324
  Attention: Film Distribution

When ordering from National Medical Audiovisual Center, (NMAC) allow at least three-weeks processing time. All NMAC orders must be in writing.

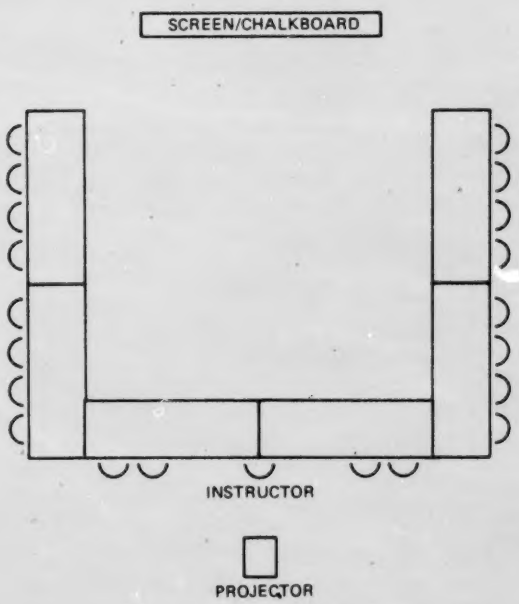


Figure 1. Sample Seating Arrangement

Since it is recommended that the handout be assigned to be read prior to the classroom period, the instructor must be certain to have enough copies of the appropriate handout (police or emergency medical technicians) made and distributed, allowing adequate time for student review. Because the handout is intended to provide basic knowledge concerning SIDS, as well as generate interest in the topic, it is suggested that the time between its distribution and the classroom session be kept to a maximum of one week. Remind the trainees to bring the handout with them to the classroom session. The instructor should also read over the handout and make notes of sections to be discussed in class.

The instructor should make copies of the case studies and distribute them to the trainees, so that they can follow along as he/she reads aloud. Depending on the amount of time available, the instructor may develop additional case studies, preferably based on personal experience. If so, a set of discussion questions should also be formulated.

Subunit 1 of the expanded curricula involves the participation of a SIDS parent. To obtain names of potential speakers for this subunit, the instructors should contact the nearest SIDS Information and Counseling Project. These federally-funded projects are located across the United States, and a list of Fiscal Year 1978 SIDS Information and Counseling Projects is included in Appendix E. If there is not one of these projects listed for your area, the following volunteer parents' organizations may be contacted:

National Sudden Infant Death Syndrome Foundation
310 South Michigan Avenue
Chicago, IL 60604
Phone: (312) 663-0650

International Council of Guilds for Infant Survival
1800 M Street, NW
Washington, DC 20001
Phone: (202) 638-7911

Subunit 2 of the expanded curricula is based on materials contained in a handout found in Appendix C and two case studies found in Appendix B. Again, the instructor must have a sufficient number of handouts and case studies to distribute. The handout should be distributed first, allowing time for student review (approximately 10 minutes). A guest speaker knowledgeable on the subjects of both child abuse/neglect and SIDS should be contacted to give a short talk and to answer any questions. If a speaker is to be used for either or both subunits, it is important that each speaker know what the students have already learned, and what topics he/she is expected to cover, so that the presentation will meet the needs of the class. This can be accomplished by providing the speaker with a copy of the handout(s), and by communicating the functions which the speaker is expected to fulfill, as described in the lesson plans.

APPENDIX A

Handout for Police Officers

Handout for Emergency Medical Technicians

SUDDEN INFANT DEATH SYNDROME (SIDS)
INFORMATION FOR
POLICE OFFICERS

INTRODUCTION

Every night many parents across this country go to bed secure in the knowledge that their babies are resting safely in their cribs only to discover their infants lifeless in the morning. Why did their healthy infants die? There was no sickness, trauma or injury to make the death understandable. These families may be shocked and confused. An urgent call for help is made, and you are the first responder.

As the first official person on the scene following the discovery of the lifeless baby, your duties in this situation may seem overwhelming. You realize that these parents are clinging to the hope that *you* can do something to save their infant, though the child is obviously dead. Not only must you try to resuscitate the infant, but you will have to deal with parental reactions ranging from numb silence to violent hysteria. It will soon become obvious to you that there are multiple victims of this tragic disease—the dead infant and the surviving family members.

The first responder must be aware of and sensitive to the traumatic condition of the parents. Life-long feelings of guilt, sibling emotional problems, divorce and even suicide are all too often the results of this tragic event. SIDS (Sudden Infant Death Syndrome) families must be treated with the same degree of compassion and sympathy as other families who lose a much loved infant to any other cause. Though you, as the first responder, cannot do anything to alleviate the parents' sorrow, you can provide emotional support and facts about SIDS which may ease their intense guilt feelings. This will be accomplished only when first responders themselves are knowledgeable about SIDS and sensitized to the needs and responses of the SIDS family.

WHAT IS SIDS?

SIDS (Sudden Infant Death Syndrome), commonly known as "crib death" or "cot death," is the number one cause of death in infants between one month and one year of age. About 6,500 babies die of SIDS every year in the United States (two per 1,000 live births). Statistics show that there has not been an increase in the number of SIDS cases in recent years, but there is more publicity about them than in the past. SIDS is an extremely widespread condition, occurring in Europe, Australia, Canada, and throughout the U. S. at similar rates. It occurs in both poor and wealthy neighborhoods; in both urban and rural communities.

SIDS is a definite disease which cannot be predicted or prevented, even by a physician. It almost always occurs during periods of sleep. The typical SIDS case involves an apparently healthy infant, usually between the ages of 4 weeks and 7 months, who has suddenly died. No illness has been present; though the baby may have had signs of a slight cold. There is no indication that the infant struggled or cried out while dying. Some-

times, though, the child has obviously changed position at the time of death.

There is evidence that SIDS has been with us since antiquity. In Biblical times it was referred to as "overlaying." Then, as occasionally occurs today, mothers slept with their infants. When a mother woke to find her child dead, it was assumed she had rolled over on him and caused his death.

There is much confusion about SIDS among both the general public and the medical profession. Not until recently has serious medical research on SIDS been conducted. However, doctors are still not certain of its exact causes. One of the hypotheses generally accepted by physicians is that death in SIDS victims occurs as the result of a complete upper airway obstruction. The death which takes place suddenly is not believed to cause pain or suffering.

The *only* way SIDS can be conclusively diagnosed is by an autopsy. Diagnosis is made only after all other causes of death have been ruled out; that is, the autopsy reveals no evidence of a rapidly fatal infectious disease, such as pneumonia or meningitis, or a previously unsuspected abnormality. Knowledge about the cause of death obtained from a thorough autopsy can ease the family's concern and intense guilt feelings.

WHAT SIDS IS NOT:

SIDS is not caused by external suffocation.

It is not uncommon for victims to be found wedged into the corner of their cribs or with their heads covered by blankets. Sometimes the face is turned down into the pillow or mattress or is discolored. Under such circumstances, it is natural to assume the baby smothered. However, SIDS also occurs under conditions where there is no possibility of smothering. Investigators have found that even when infants are covered by bedding, the amount of oxygen is not reduced to the point of causing suffocation.

SIDS is not caused by vomiting and choking.

Sometimes milk or even blood-tinged froth is found around the mouth or in the bedding. This has been shown usually to occur after death. Thus it did not block the internal air passages and cause death.

SIDS is not contagious.

SIDS is not contagious. One twin may be taken by SIDS, yet the other remains alive. SIDS is less common after the first year of life, so older children and adults are not at risk. The common viruses which appear to be associated with SIDS do not survive outside living bodies.

SIDS does not cause pain or suffering to the infant.

SIDS can occur within five minutes, and is probably instantaneous. The babies do

not cry out and often do not show even the slightest trace of having been disturbed in their sleep.

SIDS cannot be predicted.

At this time there is no known way to predict its occurrence, even if the baby saw a doctor the day of the event. Nothing the parents did or failed to do could have prevented its occurrence.

HOW CAN I TELL IF THE INFANT IS A SIDS VICTIM?

Remember that only an autopsy can determine if a death was due to SIDS. You should make no assumptions about the cause of death. You, as a first responder, can only *suspect* SIDS as the cause of death. Always give the parents the benefit of the doubt and assume SIDS until an autopsy proves otherwise. However, the fact that a healthy infant is suddenly dead may give rise to suspicions. The general appearance of the child in his crib may be misleading. There have been cases, for example, when a case of SIDS has been mistaken for child abuse. Therefore, it is necessary that you, as the first responder, know some of the identifying features characteristic of the SIDS victim as opposed to the abused child. The following table is a list of the general physical characteristics of each. This table will help you to identify the SIDS baby as well as distinguish him or her from the battered child.

Table 1

SIDS versus Child Abuse and Neglect

SIDS VICTIM	ABUSED AND NEGLECTED CHILD
1. Appears to be sleeping.	1. Adult story does not "sound right": or account for all injuries on baby.
2. May be twisted in the bed clothing.	2. Disfigurements – welts, burns, bruises, etc. – which may be in different stages of healing, or may be scars.
3. Purple mottled markings on head and facial area.	3. Broken bones.
4. Blood-tinged froth around nose and mouth areas.	4. Siblings bearing marks of child abuse.
	5. Physical evidence of general neglect of child (e.g., malnourished).

AS A POLICE OFFICER, WHAT IS MY ROLE IN THE SIDS SITUATION?

When you, the police officer, are the first to arrive at the scene of a possible SIDS death, several tasks must be performed almost simultaneously. You should first initiate resuscitative efforts if the infant is not obviously dead. You must also conduct an "investigation" that will help determine the cause of death. Finally, you must provide leadership and protection to the SIDS families.

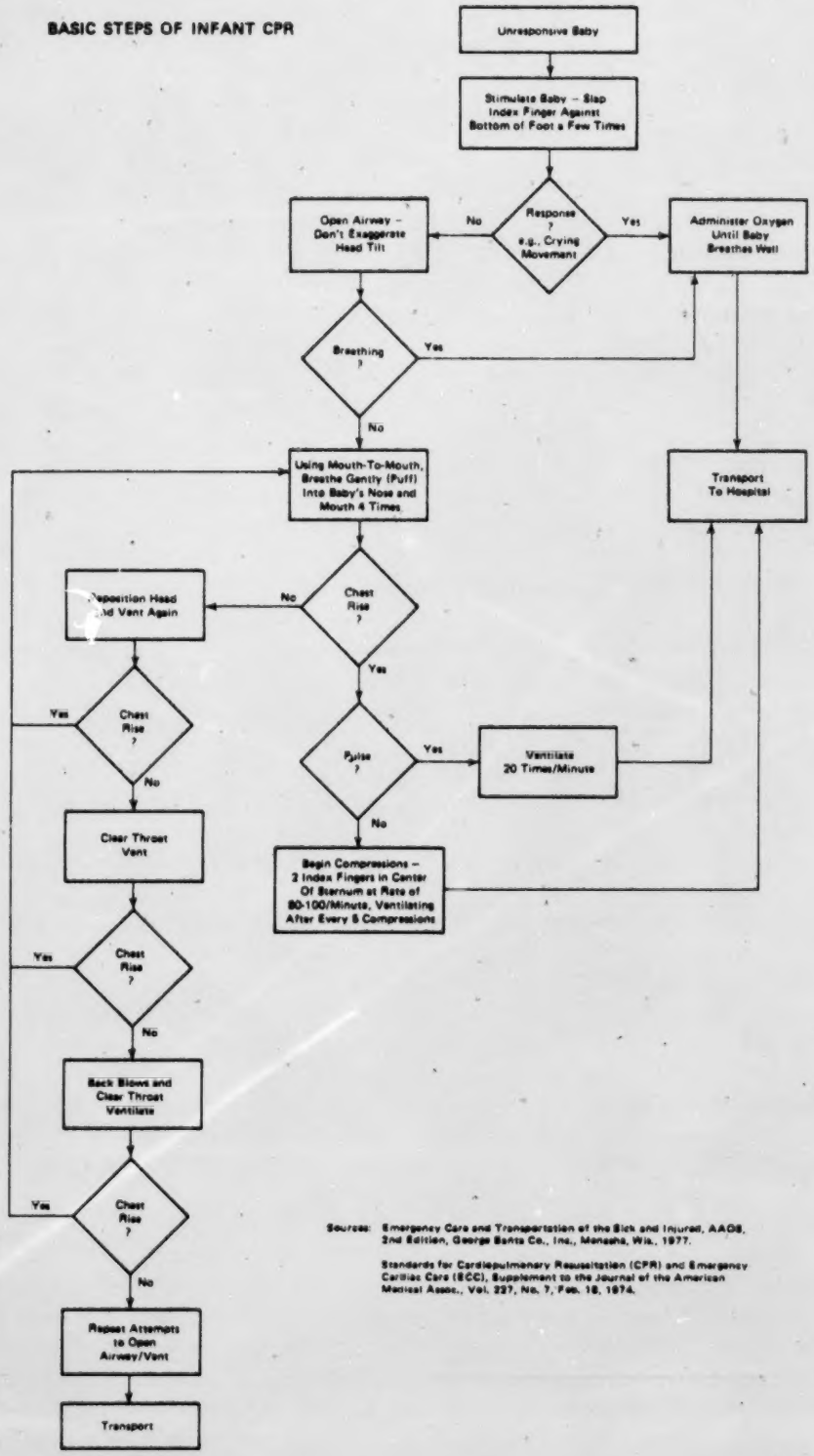
It is essential that you begin resuscitative efforts if the infant is not obviously dead. You may save a life. These efforts involve beginning infant Cardiopulmonary Resuscitation (CPR) and continuing it during the transport of the baby to the hospital. CPR is a technique requiring special training and, in some cases, State certification. If you are not trained in this technique, *do not* perform it. You may do more harm than good—you may kill the one you wish to save. If you are responding with a partner, one of you should assume this duty since it requires your complete attention.

At times, you will find a child displaying the obvious characteristics of death (e.g., rigor mortis and settling of the blood). Under normal circumstances involving a dead baby, you may be legally obligated to leave the body as is and notify the proper authorities, such as the coroner or the medical examiner. SIDS cases, however, are not "normal."

The extreme emotional condition of the parents makes them completely dependent upon you. They are looking to you for help. The best thing you can do for these parents is to make them feel that something is being done. You must understand that often parents cling to the hope that their infant is not dead and can be resuscitated, even when death is apparent. They have expectations that you can save their baby. By starting infant CPR on the obviously dead baby, you at least allow the family to have the memory that professional intervention was attempted. Leave no room for "if's" and "maybe's" (e.g., "If they had only tried, maybe . . . "). These parents will have enough self-imposed guilt and doubt to deal with as the result of SIDS. This does not mean, however, that you are to convey an attitude of false hope. Simply begin resuscitative procedures, inform the parents that everything you can do for the child is being done, and transport the infant to the hospital. To refresh your memory, the basic steps of infant CPR are shown in Figure 1.

In addition to beginning first-aid procedures on the baby, it is your job to conduct an "investigation" of the scene of the death. This involves observing the scene and making mental notes, which should be written down at the earliest opportunity. Certain questions should be asked of the parents to help clarify matters for you. This should be done as a dialogue, as opposed to an interrogation. Do not pressure the parents for answers. They may really not remember details.

BASIC STEPS OF INFANT CPR



Sources: Emergency Care and Transportation of the Sick and Injured, AAOS, 2nd Edition, George Banta Co., Inc., Menasha, Wis., 1977.

Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC), Supplement to the Journal of the American Medical Assoc., Vol. 227, No. 7, Feb. 18, 1974.

Figure 1

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Things to Look For and Note

- Physical appearance of baby.
- Position of baby in crib—may account for marks on child's head or body.
- Physical appearance of crib.
- Appearance of room/house.
- Behaviors of persons present.

Facts About Baby

- Circumstances concerning discovery of unresponsive child:

  Who discovered and what did that person do.

  When discovered.

  Where discovered.

  How discovered (e.g., did mother go in first thing in morning? Routine check on baby during nap? Did they hear anything?).

- Any first-aid efforts attempted? (This may account for some marks on the body.)
- When was baby put to bed? Or when did baby fall asleep?
- Age and weight of child.
- Problems at birth?
- Describe infant's general health.
- Any recent illness?
- Results of last physical exam?

Much of this type of information will be naturally forthcoming. Encourage the parents to talk, to tell their story. Ask open-ended questions, such as "What happened?" It may then be a matter of simply writing the information down. A sample SIDS information form developed under DHEW sponsorship is contained in Figure 2. Your department or service may already require you to fill out a form which contains much of the same information.

INVESTIGATIVE FINDINGS

ID NO._____ _____

SUBJECT DATA

Age (wks):_____ Date of Birth:_____
Sex: M F
Race:_____
Last seen alive; Date:_____ Time:_____
Found dead: Date:_____ Time:_____
Observed to die: No:_____ Yes:_____ Describe:_____
_____
_____
Place of Death: Own Crib:_____ No. in bed:_____
Parents' bed:_____
Other:_____ Describe:_____
_____
Resuscitation attempted: Yes:_____ No:_____ Unknown:_____
Birth weight:_____
Illness in last two weeks: Yes:_____ No:_____
Cold, sniffles:_____
G. I. Symptoms:_____
Other minor:_____
Other major:_____ Describe:_____
_____
Medical treatment during last week of life? Yes:_____ No:_____ Unknown:_____
Prior major illness: Yes:_____ No:_____ Unknown:_____
Well baby visits: Yes:_____ No:_____ Unknown:_____
Breast fed: Yes:_____ No:_____ Unknown:_____
At time of death: Yes:_____ No:_____ Unknown:_____
Any cow's milk in past: Yes:_____ No:_____ Unknown:_____

PARENTAL AND GESTATIONAL DATA

Maternal age (yrs):_____ Married:_____ Single:_____
Widowed:_____ Divorced:_____
Paternal age (yrs):_____
Length of gestation (wks)_____ (40 weeks = term)
Complication of gestation: Yes:_____ No:_____ Describe:_____
_____
Complication of delivery: Yes:_____ No:_____ Describe:_____
_____

Figure 2
PO-7 of 13

Number prenatal clinic visits: 0____ 4 _____
1____ 74 _____
2____ Unk ____
3____

Unusual nutritional habits: _____

Unusual drug usage: _____

FAMILIAL DATA

Other SIDS cases: Yes: _____ No: _____ Describe: _____

Number of previous pregnancies: _____

Number of live births: _____

Number of living sibs: _____

Comments: _____

_____

_____

SOCIO ECONOMIC & ENVIRONMENTAL DATA

Family income: Less than $5,000/yr _____ Welfare: Yes _____ No _____
5-10,000 _____
10-20,000 _____
More than 20,000/yr _____

Address where death occurred: _____

Home characteristics: Single family: _____ Multifamily: _____

General quality of dwelling: Below average: ____
Average: _____
Above average: ____

Number of inhabitants in family dwelling: Adults: _____
Children: _____
Smokers: _____

Unusual environmental circumstances: Yes: _____ No: _____ Describe: _____

_____

Neighborhood: Urban industrial _____
Urban (dense) residentail _____
Suburban (non-dense) residential _____
Semi-rural (less than 1 home/acre) _____
Rural (less than 1 home/10 acres) _____

Figure 2 (continued)

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At times, certain items should be preserved for further investigation. This can be done by either taking them with the infant to the hospital or by making sure they remain in their original position until the death scene can be thoroughly investigated. It should be emphasized here that a criminal investigation should be conducted *only* after the autopsy has shown positive evidence of an unnatural death. There is no need to put these families through the ordeal and overriding implications of an investigation if all indicators point to SIDS. However, you should be aware of what to preserve, should the need arise.

Evidence to Preserve

- Infant's bedding (sheets, blankets, etc.).
- Objects in crib (toys, bottles, etc.).
- Unusual or dangerous items found near death scene (plastic bags, sharp objects, paint chips, etc.).
- Medications—even adult (Note: you may wish to take with you to hospital).

When the time comes to transport the infant to a hospital, you should take charge of the situation. Make sure you tell the parents where you are taking the child. The parents should be allowed to accompany their baby in the police car. If not, give them clear directions regarding where you are taking their baby. Often the parents are in such a state of emotional shock that they are not capable of driving themselves to the hospital. In this case, make other arrangements to get them to the hospital (e.g., taxicab or neighbor). The parents may also need to be reminded to arrange for the care of the siblings. A member of your police team may volunteer to assist in such details.

Once you deliver the baby into the hands of the Emergency Department staff, there is nothing more you can do for him or her. Your attention is now turned to the family of the SIDS victim.

The reactions of family members to the SIDS incident will be as individual as they are. Many factors can affect these reactions: situation of child's death, meaning child had to the individual, marriage relationship, cultural background. You must not misinterpret or read into these reactions. And you, as the first responder, will have to be prepared to deal with them all.

One of the most common immediate reactions to SIDS is shock and disbelief. This may cause family members to become immobilized—incapable of making decisions. Or this may cause them to act as if nothing has really happened. Externally, it may appear as if the parents are cold and unfeeling. It is not that they do not care, but just that they are having a hard time facing reality.

It will be difficult for you to deal with these parents whose reactions are extreme. Some parents may physically act out their emotions, resulting in hysteria, crying or wailing. Parents may be confused and overwhelmed with guilt feelings, unfairly venting

their anger and frustration on you. When anger is aimed at you, or perhaps your professional capabilities questioned, your natural tendency is to retaliate with your own angry remarks, which only compounds the problems.

How can the police officer help the SIDS survivors in this difficult situation? First, you, as a professional, must be in command of your own feelings and behavior at all times. Act in a calm, efficient manner, exhibiting kind concern. While in the home, make the parents feel that something is being done. Explain what you are doing and where you are taking the child. Take command of the situation and try to protect the family from any further stress. At the hospital emergency room, try to keep the parents informed of the child's status. Be careful of what you say to your colleagues at the hospital. Casual comments such as "smothered" or "injured" may be overheard by the family and cause unnecessary emotional distress. Small, often nonverbal, gestures on your part are very important. By simply sitting with the parents, you are showing them that someone cares. Offer to be of assistance to them—to make phone calls or to get them coffee. A sympathetic ear may be all these parents need.

Be careful not to "diagnose" the child's problem or to speculate on the outcome. Let all medical information come from the emergency room physician. If you have any questions or comments, or wish confirmation that the child is a SIDS victim, discuss these matters privately with emergency room personnel.

The interview following a sudden infant death will be difficult for both you and the parents. You may already have much of the information you need to complete your report. If SIDS is indicated by the emergency physician as the cause of death, you should explain to them about the disease. Reassure them that they are in no way responsible for the death. If you need additional information, explain that the questioning is routine and necessary to complete your report. The emotional state of the parents may be such that you may wish to postpone the questioning.

The questioning should be done as an interview. Ask open-ended questions such as, "How was the baby yesterday?" Do not ask leading questions or suspicious questions (e.g., "You weren't drunk last night, were you?"). Do not ask questions that show you might doubt their capabilities as parents (e.g., "How often did you spank the baby?"). Give your full attention to the parents and listen "actively" to what they are saying.

You will be able to obtain much information if you let the parents tell their story while you actively listen. Encourage them to continue talking by nodding and saying, "Um hm" or "Yes, go on." Try to remain objective—do not express approval/disapproval with any of the actions or facts related. Try not to interrupt except to clarify something they say. If the parents become upset, wait quietly for a minute or two, then encourage them to continue talking by saying something like, "You were saying . . . " At the end of the questioning session, look over your notes to make sure all the necessary information has been obtained.

The time you spend with these families may be brief, but it can have a significant positive impact which influences their recovery from this tragic event.

STUDY QUESTIONS

The following are some self-study questions about SIDS based on the material in this handout. Select the best answer(s) for each. The correct answers are found on the last page.

1. From the following list of physical features, check those which commonly identify a SIDS Victim.

    a. Twisted in bed clothing.
    b. Drainage from ears.
    c. Appears to be sleeping.
    d. Mottled markings on head and face.
    e. Bloated appearance.
    f. Face distorted with pain.
    g. Froth around nose and mouth.
    h. Skin bright red in color.

2. List six things to look for at the site where an infant has suddenly died:

    1. _____
    2. _____
    3. _____
    4. _____
    5. _____
    6. _____

3. When a child has suddenly died, the parents become the "victims" and must be treated accordingly in order to:

    a. Preserve the evidence for further investigation.
    b. Help alleviate the guilt and suffering.
    c. Prevent further spread of the disease.
    d. All of the above.

4. One of the generally accepted hypotheses as to the cause of SIDS is that it is a contagious viral infection transmitted by certain animals.

    True or False?

5. Which of the following statements are true about SIDS?

a. It is most commonly found among the middle classes.
b. It almost always occurs while the baby is sleeping.
c. It is the leading cause of death in babies between the ages of one month and one year.
d. An autopsy will usually disclose evidence of illness or a previously undetected abnormality as the cause of death.
e. It is a disease which cannot be predicted or prevented, even by a physician.
f. It is a relatively new disease, probably due to certain environmental pollutants.
g. It can be identified by the first responder who is alert to the signs of SIDS.
h. It is virtually impossible to distinguish between child abuse and a SIDS incident.

6. Place an "X" beside those statements which describe the way a police officer should respond when an infant has suddenly died.

a. Two police officers respond to the call. While one is beginning infant CPR, the other asks the mother if she dropped the baby in order to account for a mark on the child's head.
b. Police Officer tells mother that she should have called sooner, since it's too late for him to do anything now.
c. During the questioning, officers ask open-ended questions and encourage the parents to tell their "story."
d. Police officers begin procedures for a criminal investigation, and ask the parents to remain at home for further questioning.
e. After arriving at the hospital emergency room, police go to the coffee shop to await the final diagnosis from the emergency physician because they think the parents would rather be left alone.
f. A member of the police team volunteers to arrange for a baby sitter so the parents can accompany the infant to the hospital.
g. The first police officer begins resuscitation procedures while the partner writes down information concerning the scene of the death.
h. While waiting at the emergency room, police officers sit quietly with parents, offering assistance and support.

ANSWERS TO SELF-STUDY QUESTIONS

1. a, c, d, g

2. Any of the following:

   - Physical appearance of baby.
   - Position of baby in crib—may account for marks on child's head or body.
   - Physical appearance of crib.
   - Presence of objects in crib and what they are.
   - Unusual or dangerous items in room (sharp objects, plastic bags, etc.).
   - Appearance of room/house.
   - Presence of medication—even adult.
   - Behaviors of persons present.

3. b

4. False. One of the hypotheses generally accepted by physicians is that death in SIDS victims occurs as the result of a complete upper airway obstruction.

5. b, c, e, g

6. c, f, g, h

SUDDEN INFANT DEATH SYNDROME (SIDS)
INFORMATION FOR
EMERGENCY MEDICAL TECHNICIANS

INTRODUCTION

Every night many parents across this country go to bed secure in the knowledge that their babies are resting safely in their cribs only to discover their infants lifeless in the morning. Why did their healthy infants die? There was no sickness, trauma or injury to make the death understandable. These families may be shocked and confused. An urgent call for help is made, and you are the first responder.

As the first official person on the scene following the discovery of the lifeless baby, your duties in this situation may seem overwhelming. You realize that these parents are clinging to the hope that *you* can do something to save their infant, though the child is obviously dead. Not only must you try to resuscitate the infant, but you will have to deal with parental reactions ranging from numb silence to violent hysteria. It will soon become obvious to you that there are multiple victims of this tragic disease—the dead infant and the surviving family members.

The first responder must be aware of and sensitive to the traumatic condition of the parents. Life-long feelings of guilt, sibling emotional problems, divorce and even suicide are all too often the results of this tragic event. SIDS (Sudden Infant Death Syndrome) families must be treated with the same degree of compassion and sympathy as other families who lose a much loved infant to any other cause. Though you, as the first responder, cannot do anything to alleviate the parents' sorrow, you can provide emotional support and facts about SIDS which may ease their intense guilt feelings. This will be accomplished only when first responders themselves are knowledgeable about SIDS and sensitized to the needs and responses of the SIDS family.

WHAT IS SIDS?

SIDS (Sudden Infant Death Syndrome), commonly known as "crib death" or "cot death," is the number one cause of death in infants between one month and one year of age. About 6,500 babies die of SIDS every year in the United States (two per 1,000 live births). Statistics show that there has not been an increase in the number of SIDS cases in recent years, but there is more publicity about them than in the past. SIDS is an extremely widespread condition, occurring in Europe, Australia, Canada, and throughout the U. S. at similar rates. It occurs in both poor and wealthy neighborhoods; in both urban and rural communities.

SIDS is a definite disease which cannot be predicted or prevented, even by a physician. It almost always occurs while the baby is sleeping. The typical SIDS case involves an apparently healthy infant, usually between the ages of 4 weeks and 7 months, who has suddenly died overnight in his crib. No illness has been present; though the baby may have had signs of a slight cold. There is no indication that the infant struggled or cried out while dying. Sometimes, though, the child has obviously changed position at the time of death.

There is evidence that SIDS has been with us since antiquity. In Biblical times it was referred to as "overlaying." Then, as occasionally occurs today, mothers slept with their infants. When a mother woke to find her child dead, it was assumed she had rolled over on him and caused his death.

There is much confusion about SIDS among both the general public and the medical profession. Not until recently has serious medical research on SIDS been conducted. However, doctors are still not certain of its exact causes. One of the hypotheses generally accepted by physicians is that death in SIDS victims occurs as the result of a complete upper airway obstruction. The death which takes place suddenly is not believed to cause pain or suffering.

The *only* way SIDS can be conclusively diagnosed is by an autopsy. Diagnosis is made only after all other causes of death have been ruled out; that is, the autopsy reveals no evidence of a rapidly fatal infectious disease, such as pneumonia or meningitis, or a previously unsuspected abnormality. Knowledge about the cause of death obtained from a thorough autopsy can ease the family's concern and intense guilt feelings.

WHAT SIDS IS NOT:

SIDS is not caused by external suffocation.

It is not uncommon for victims to be found wedged into the corner of their cribs or with their heads covered by blankets. Sometimes the face is turned down into the pillow or mattress or is discolored. Under such circumstances, it is natural to assume the baby smothered. However, SIDS also occurs under conditions where there is no possibility of smothering. Investigators have found that even when infants are covered by bedding, the amount of oxygen is not reduced to the point of causing suffocation.

SIDS is not caused by vomiting and choking.

Sometimes milk or even blood-tinged froth is found around the mouth or in the bedding. This has been shown usually to occur after death. Thus it did not block the internal air passages and cause death.

SIDS is not contagious.

SIDS is not contagious. One twin may be taken by SIDS, yet the other remains alive. SIDS is less common after the first year of life, so older children and adults are not at risk. The common viruses which appear to be associated with SIDS do not survive outside living bodies.

SIDS does not cause pain or suffering to the infant.

SIDS can occur within five minutes, and is probably instantaneous. The babies do not cry out and often do not show even the slightest trace of having been disturbed in their sleep.

SIDS cannot be predicted.

At this time there is no known way to predict its occurrence, even if the baby saw a doctor the day of the event. Nothing the parents did or failed to do could have prevented its occurrence.

HOW CAN I TELL IF THE INFANT IS A SIDS VICTIM?

Remember that only an autopsy can determine if a death was due to SIDS. You should make no assumptions about the cause of death. You, as a first responder, can only *suspect* SIDS as the cause of death. Always give the parents the benefit of the doubt and assume SIDS until an autopsy proves otherwise. However, the fact that a healthy infant is suddenly dead may give rise to suspicions. The general appearance of the child in his crib may be misleading. There have been cases, for example, when a case of SIDS has been mistaken for child abuse. Therefore, it is necessary that you, as the first responder, know some of the identifying features characteristic of the SIDS victim as opposed to the abused child. The following table is a list of the general physical characteristics of each. This table will help you to identify the SIDS baby as well as distinguish him or her from the battered child.

Table 1

SIDS versus Child Abuse and Neglect

SIDS VICTIM	ABUSED AND NEGLECTED CHILD
1. Appears to be sleeping	1. Adult story does not "sound right": or account for all injuries on baby.
2. May be twisted in the bed clothing.	2. Disfigurements — welts, burns, bruises, etc. — which may be in different stages of healing, or may be scars.
3. Purple mottled markings on head and facial area.	3. Broken bones.
4. Blood-tinged froth around nose and mouth areas.	4. Siblings bearing marks of child abuse.
	5. Physical evidence of general neglect of child (e.g., malnourished).

AS AN EMERGENCY MEDICAL TECHNICIAN (EMT), WHAT IS MY ROLE IN THE SIDS SITUATION?

If the child is not obviously dead, your first responsibility is to the apparently lifeless infant. You should immediately initiate resuscitative efforts on the child. This involves beginning infant CPR and continuing it during the transport of the baby to the hospital. Determine if any first-aid efforts were made by the parents. (This may account for some marks on the body.)

At times, you will find a child displaying the obvious characteristics of death (e.g., rigor mortis and settling of the blood). Under normal circumstances involving a dead baby, you may be legally obligated to leave the body as is and notify the proper authorities, such as the coroner or the medical examiner. SIDS cases, however, are not "normal."

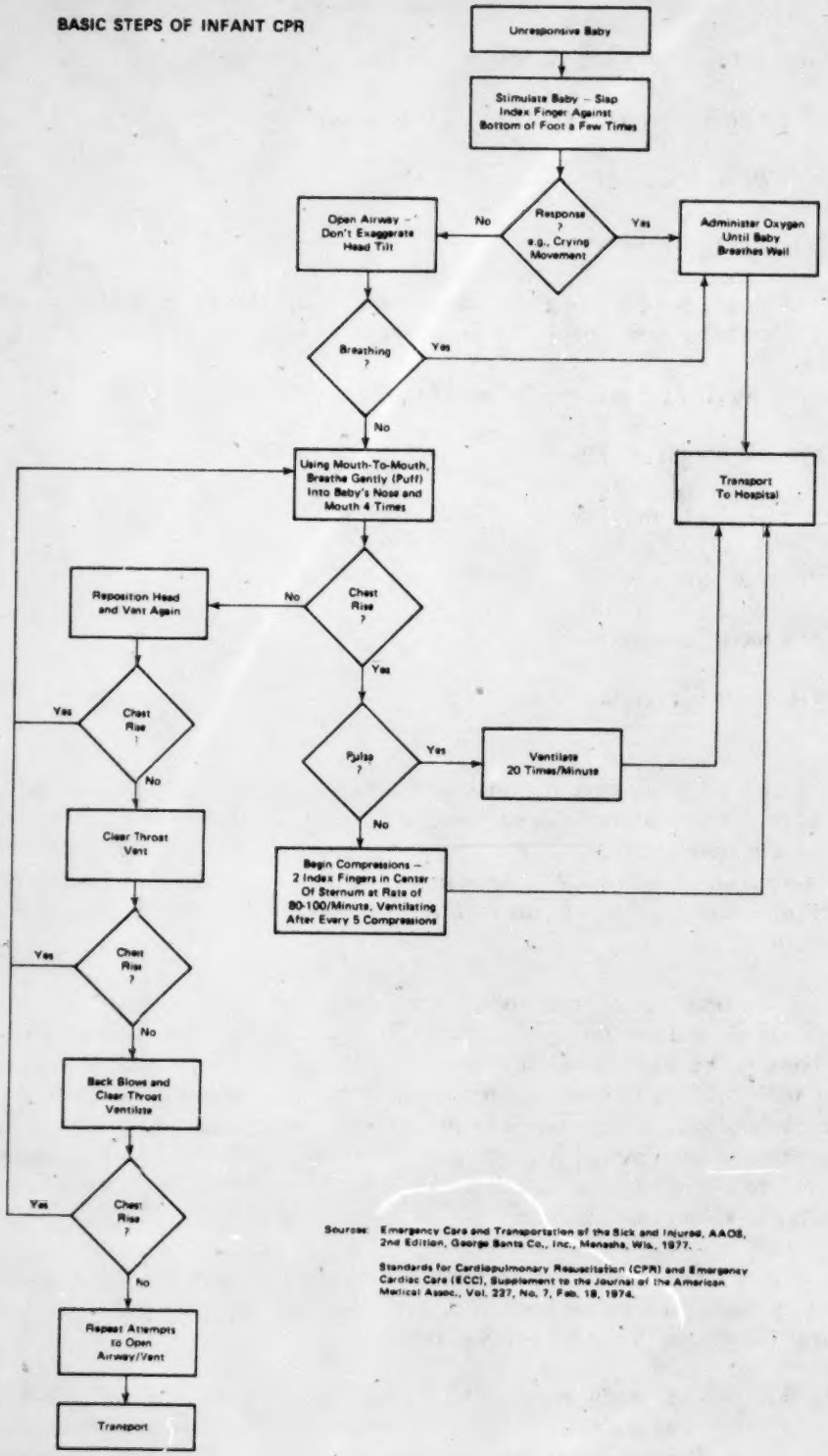
The extreme emotional condition of the parents makes them your patients as much as the infant. They must be "treated," also. The best method of treatment for these parents is to make them feel that something is being done. You must understand that often parents cling to the hope that their infant is not dead and can be resuscitated, even when death is apparent. They have expectations that you can save their baby. By starting infant CPR on the obviously dead baby, you at least allow the family to have the memory that professional intervention was attempted. Leave no room for "if's" and "maybe's" (e.g., "If they had only tried, maybe . . . ."). These parents will have enough self-imposed guilt and doubt to deal with as the result of SIDS. This does not mean, however, that you are to convey an attitude of false hope. Simply begin resuscitative procedures, inform the parents that everything you can do for the child is being done, and transport the infant to the hospital. To refresh your memory, the basic steps of infant CPR are shown in Figure 1.

In addition to beginning resuscitative measures on the child, you should note, perhaps in writing, various things and obtain a brief medical history of the infant.

Things to Look for and Note

- Physical appearance of baby.
- Position of baby in crib—may account for marks on child's head or body.
- Physical appearance of crib.
- Presence of objects in crib and what they are.
- Unusual or dangerous items in room (sharp objects, plastic bags, etc.).
- Appearance of room/house.
- Presence of medication—even adult. (Note: You may wish to take medications with you to hospital.)
- Behaviors of persons present.

BASIC STEPS OF INFANT CPR



Sources: Emergency Care and Transportation of the Sick and Injured, AAOS, 2nd Edition, George Banta Co., Inc., Menasha, Wis., 1977.

Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC), Supplement to the Journal of the American Medical Assoc., Vol. 227, No. 7, Feb. 18, 1974.

Figure 1

Facts About Baby

– Circumstances concerning discovery of unresponsive child.

  Who discovered, and what did that person do.

  When discovered.

  Where discovered.

  How discovered (e.g., did mother go in first thing in morning? Routine check on baby during nap? Did they hear anything?).

– When was baby put to bed? Or when did baby fall asleep?

– Age and weight of child.

– Problems at birth?

– Describe general health.

– Any recent illness?

– Results of last physical exam?

Much of this type of information will be naturally forthcoming. Encourage the parents to talk, to tell their story. Ask open-ended questions, such as "What happened?" It may then be a matter of simply writing the information down. A sample SIDS information form developed under DHEW sponsorship is contained in Figure 2. Your department or service may already require you to fill out a form which contains much of the same information.

When the time comes to transport the infant to a hospital, make sure you tell the parents where you are taking the child. The parents should be allowed to accompany their baby in the ambulance. If not, give them clear directions regarding where you are taking their baby. Often the parents are in such a state of emotional shock that they are not capable of driving themselves to the hospital. In this case, make other arrangements to get them to the hospital (e.g., taxicab or neighbor). The parents may also need to be reminded to arrange for the care of the siblings. A member of your emergency team may volunteer to assist in such details.

Once you deliver the baby into the hands of the Emergency Department Staff, there is nothing more you can do for him or her. Your attention is now turned to your other "patients" – the family of the SIDS victim.

The reactions of family members to the SIDS incident will be as individual as they are. Many factors can affect these reactions: situation of child's death, meaning child had to the individual, marriage relationship, cultural background. You must not misinterpret or

INVESTIGATIVE FINDINGS

ID NO._____

SUBJECT DATA

Age (wks):_____ Date of Birth:_____
Sex: M F
Race:_____
Last seen alive; Date:_____ Time:_____
Found dead: Date:_____ Time:_____
Observed to die: No:_____ Yes:_____ Describe:_____
_____
_____
Place of Death: Own Crib:_____ No. in bed:_____
Parents' bed:_____
Other:_____ Describe:_____
_____
Resuscitation attempted: Yes:_____ No:_____ Unknown:_____
Birth weight:_____
Illness in last two weeks: Yes:_____ No:_____
Cold, sniffles:_____
G. I. Symptoms:_____
Other minor:_____
Other major:_____ Describe:_____
_____
Medical treatment during last week of life? Yes:_____ No:_____ Unknown:_____
Prior major illness: Yes:_____ No:_____ Unknown:_____
Well baby visits: Yes:_____ No:_____ Unknown:_____
Breast fed: Yes:_____ No:_____ Unknown:_____
At time of death: Yes:_____ No:_____ Unknown:_____
Any cow's milk in past: Yes:_____ No:_____ Unknown:_____

PARENTAL AND GESTATIONAL DATA

Maternal age (yrs):_____ Married:_____ Single:_____
Widowed:_____ Divorced:_____
Paternal age (yrs):_____
Length of gestation (wks)_____ (40 weeks = term)
Complication of gestation: Yes:_____ No:_____ Describe:_____
_____
Complication of delivery: Yes:_____ No:_____ Describe:_____
_____

Figure 2
EMT-7 of 12

Number prenatal clinic visits: 0 ____ 4 ____
1 ____ 74 ____
2 ____ Unk ____
3 ____

Unusual nutritional habits: _____

Unusual drug usage: _____

FAMILIAL DATA

Other SIDS cases: Yes: _____ No: _____ Describe: _____

Number of previous pregnancies: _____

Number of live births: _____

Number of living sibs: _____

Comments: _____

_____

_____

SOCIO ECONOMIC & ENVIRONMENTAL DATA

Family income: Less than $5,000/yr _____ Welfare: Yes _____ No _____
5-10,000 _____
10-20,000 _____
More than 20,000/yr _____

Address where death occurred: _____

Home characteristics: Single family: _____ Multifamily: _____

General quality of dwelling: Below average: _____
Average: _____
Above average: _____

Number of inhabitants in family dwelling: Adults: _____
Children: _____
Smokers: _____

Unusual environmental circumstances: Yes: _____ No: _____ Describe: _____

_____

Neighborhood: Urban industrial _____
Urban (dense) residentail _____
Suburban (non-dense) residential _____
Semi-rural (less than 1 home/acre) _____
Rural (less than 1 home/10 acres) _____

Figure 2 (continued)
EMT-8 of 12

read into these reactions. And you, as the first responder, will have to be prepared to deal with them all.

One of the most common immediate reactions to SIDS is shock and disbelief. This may cause family members to become immobilized—incapable of making decisions. Or this may cause them to act as if the parents are cold and unfeeling. It is not that they do not care, but just that they are having a hard time facing reality.

It will be difficult for you to deal with these parents whose reactions are extreme. Some parents may physically act out their emotions, resulting in hysteria, crying or wailing. Parents may be confused and overwhelmed with guilt feelings, unfairly venting their anger and frustration on you. When anger is aimed at you, or perhaps your professional capabilities questioned, your natural tendency is to retaliate with your own angry remarks, which only compounds the problems.

All too often, EMTs are quick to dismiss the parents because they are not their patients, in the traditional sense of the word. You tend to ignore the mother's barrage of questions concerning her child, and politely tell her to go away. You are there to deliver medical care in an emergency situation, not to get "involved." You are not being asked to get personally involved, but to understand that these parents and family members need your care, also. Their need may not be as obvious to you as an open wound, but the hurt is there and is very real. If left untreated, it may scar or never heal at all.

How can you help the SIDS survivors in this difficult situation? First, you, as a professional, must be in command of your own feelings and behavior at all times. Act in a calm, efficient manner, exhibiting kind concern. While in the home, make the parents feel that something is being done. Explain what you are doing and where you are taking the child. Take command of the situation and try to protect the family from any further stress. At the hospital emergency room, try to keep the parents informed of the child's status. Be careful of what you say to your colleagues at the hospital. Casual comments such as "smothered" or "injured" may be overheard by the family and cause unnecessary emotional distress. Small, often nonverbal, gestures on your part are very important. By simply sitting with the parents you are showing them that someone cares. Offer to be of assistance to them—to make phone calls or to get them coffee. A sympathetic ear may be all these parents need.

Be careful not to "diagnose" the child's problem or to speculate on the outcome. Let all medical information come from the emergency room physician. If you have any questions or comments, or wish confirmation that the child is a SIDS victim, discuss these matters privately with emergency room personnel. If SIDS is indicated by the emergency physician as the cause of death, you should explain to the parents about the disease. Help to reassure them that they are in no way responsible for the death. Your time with the family may be brief, but it can greatly influence their recovery.

STUDY QUESTIONS

The following are some self-study questions about SIDS based on the material in this handout. Select the best answer(s) for each. The correct answers are found on the last page.

1. From the following list of physical features, check those which commonly identify a SIDS Victim.

    a. Twisted in bed clothing.
    b. Drainage from ears.
    c. Appears to be sleeping.
    d. Mottled markings on head and face.
    e. Bloated appearance.
    f. Face distorted with pain.
    g. Froth around nose and mouth.
    h. Skin bright red in color.

2. List six things to look for at the site where an infant has suddenly died:

    1. _____
    2. _____
    3. _____
    4. _____
    5. _____
    6. _____

3. When a child has suddenly died, the parents become the "patients" and must be treated accordingly in order to:

    a. Preserve the evidence for further investigation.
    b. Help alleviate the guilt and suffering.
    c. Prevent further spread of the disease.
    d. All of the above.

4. One of the generally accepted hypotheses as to the cause of SIDS is that it is a contagious viral infection transmitted by certain animals.

    True or False?

5. Which of the following statements are true about SIDS?

a. It is most commonly found among the middle classes.
b. It almost always occurs while the baby is sleeping.
c. It is the leading cause of death in babies between the ages of one month and one year.
d. An autopsy will usually disclose evidence of illness or a previously undetected abnormality as the cause of death.
e. It is a disease which cannot be predicted or prevented, even by a physician.
f. It is a relatively new disease, probably due to certain environmental pollutants.
g. It can be identified by the first responder who is alert to the signs of SIDS.
h. It is virtually impossible to distinguish between child abuse and a SIDS incident.

6. Place an "X" beside those statements which describe the way an EMT should respond when an infant has suddenly died.

a. Two EMTs respond to the call. While one is beginning infant CPR, the other asks the mother if she dropped the baby in order to account for a mark on the child's head.
b. EMT asks father to please stay at home and tend to emotionally wrought mother while the baby is transported to the hospital.
c. EMTs begin CPR on infant, allow parents to accompany child in ambulance, and transport them to the hospital.
d. EMT tells parents that he will begin CPR. However, not wanting to raise false hopes, he also tells them that he thinks it will be futile because the baby is too far gone.
e. After arriving at the hospital emergency room, EMTs go to the coffee shop to await the final diagnosis from the emergency physician because they think the parents would rather be left alone.
f. A member of the emergency team volunteers to arrange for a baby sitter so the parents can accompany the infant to the hospital.
g. The first EMT begins infant CPR while the partner writes down the baby's medical history and other possibly important information.
h. While waiting at the emergency room, EMTs sit quietly with parents offering assistance and support.

ANSWERS TO SELF-STUDY QUESTIONS

1. a, c, d, g

2. Any of the following:

   - Physical appearance of baby.
   - Position of baby in crib—may account for marks on child's head or body.
   - Physical appearance of crib.
   - Presence of objects in crib and what they are.
   - Unusual or dangerous items in room (sharp objects, plastic bags, etc.).
   - Appearance of room/house.
   - Presence of medication—even adult.
   - Behaviors of persons present.

3. b

4. False. One of the hypotheses generally accepted by physicians is that death in SIDS victims occurs as the result of a complete upper airway obstruction.

5. b, c, e, g

6. c, f, g, h

APPENDIX B

Case Studies

CASE STUDY #1

A call comes in to the dispatch center at 7:40 am. A baby at 903 Benson Avenue is not breathing. Benson Avenue is in one of the wealthier sections of the city, and you and your partner respond within five minutes. The mother, about 30 years old, meets you at the door of the house and rushes you upstairs to an otherwise neat and clean nursery, except for a plastic bottle dripping milk on the floor next to the crib. The mother is pale and visibly shaken - she'd obviously been crying. She tells you her son, Roger, is 3-1/2 months old. She thought she had heard him stirring about 7:30 this morning for his morning feeding. She had gotten his bottle of formula ready and had come upstairs to find him just lying there not moving. She says she does not remember too much after that, except calling the police and her husband's office. She goes on to tell you that Roger had been to the pediatrician two days ago because of a cold and a mild case of diarrhea. The doctor had given him a shot and some medication, and things were improving. She looks over at the crib and begins sobbing uncontrollably.

CASE STUDY #2

You respond to a call in an apartment building which is part of the public housing development. An older woman, about 65, is nervously waiting for you in the hallway. "Where the [EXPLETIVE DELETED] you been, you took so [EXPLETIVE DELETED] long," she screams, and practically shoves you into the apartment. "She's in there, go on, hurry!" You go into the bedroom and find the baby girl, about six months old, lying motionless on the bed. The bedroom is poorly furnished, but clean--there is nothing unusual about the room. The baby is slightly twisted in her blanket and has a foamy discharge around her nose and mouth. Your partner is talking to the woman, who is the baby's grandmother. Both parents are at work. Your partner asks what happened, and the grandmother begins shouting obscenities. "[EXPLETIVE DELETED], if I knew, why would I call you? You tell me, you [EXPLETIVE DELETED] or are you too [EXPLETIVE DELETED] stupid to know?" This type of verbal abuse continues. All the useful information you can pick out of the screaming and yelling is that the baby did not wake up after her mid-morning nap. Neighbors are beginning to crowd around the open door.

CASE STUDY #3

You are a young parent with two children. Chris, age four, is an active little boy who recently fell off his tricycle and broke his arm. Debbie, four months, is a healthy, happy baby, although she did seem to have a slight cold yesterday. You have always thought of yourself as a conscientious, loving parent. This morning, Debbie did not awaken at 6:30 for her usual morning feeding. At 7:00, you went in to check on her, and found her lying in her crib, cold and apparently lifeless. You immediately called for help and a police car arrived within a few minutes. Meanwhile, Chris woke up and kept asking, "What's wrong with Debbie? Why doesn't she wake up?" One of the police officers made a comment about Chris' broken arm, and you gave him a vague reply. You are in a state of shock, and have been moving around and answering questions automatically. The other officer observes, as he is making notes, "bluish discolorations on the baby's body--look like bruises. Bloody discharge from nose." You hear the two officers talking together in low voices, and then you are jolted back to full awareness when one of them says to you, "I'll have to ask you to come down to the station for questioning. This looks like a case of possible child abuse."

CASE STUDY #4

You are 19 years old. You have always been a "loner," and never dated much, but you suddenly found yourself in a situation where you "had to" get married. When the baby arrived two months ago, you had very little feeling for it. After all, if it hadn't been for the baby, you wouldn't be trapped in this marriage that you really weren't ready for. Besides, the baby always wanted attention, always seemed to start crying when you wanted to get some sleep. You started slapping the baby to get it to stop crying. This time, you couldn't make it stop, so you shook it, harder and harder. All of a sudden you heard a "snap," and the baby's head kind of fell over to one side, and it stopped crying. Now, the baby doesn't seem to be breathing, and it feels limp.

APPENDIX C

Handout — SIDS Versus Child Abuse and Neglect

HOW TO DISTINGUISH BETWEEN SIDS AND CHILD ABUSE AND NEGLECT	
Sudden Infant Death Syndrome versus	Child Abuse/Neglect
Incidence: Deaths: 6,500/year Highest: 2 to 4 months of age When: Winter months	Incidence: Deaths: 1,000 to 4,000/year Deaths in Infants: 300/year Highest: 1 to 3 years of age When: No seasonal difference
Physical Appearance: 1. Exhibit no external signs of injury Exhibit "natural" appearance of dead baby: a. lividity—settling of blood b. frothy drainage from nose/ mouth c. small marks (e.g., diaper rash) look more severe d. cooling/rigor mortis—takes place quickly in infant (about three hours) 2. Appears to be a well-developed baby, though may be small for age. 3. Other siblings appear to be normal and healthy.	Physical Appearance: 1. Distinguishable and visible signs of injury: a. Bruises b. Burns c. Cuts d. Welts e. Wounds f. Scars g. Head trauma (e.g., black eye) h. Broken bone(s) 2. May be obviously wasted away (starvation victim). 3. Other siblings may show patterns of injuries commonly seen in child abuse and neglect.
May Initially Suspect SIDS: 4. All of the above characteristics plus 5. Parents say that infant was well and healthy when put to sleep (last time seen alive).	May Initially Suspect Child Abuse/ Neglect 4. All of the above characteristics plus 5. Parents' story does not "sound right" or account for all injuries on infant.

APPENDIX D

CONTENT OUTLINE--A Call for Help

CONTENT OUTLINE

A Call for Help

I. Treatment of SIDS family at home.

A. Make no assumptions about cause of problem or death.

B. Do not pronounce infant dead.

C. Make parents feel that something is being done - this may involve beginning infant CPR.

D. Explain what you are doing, or where you are taking the infant.

E. Make no statement about the condition of the child.

F. Arrange to transport parents to hospital.

G. Help arrange for someone to care for siblings.

II. Possible parental emotional reactions to be encountered by first responder.

A. Each family, and each family member, is unique and will respond to the death in a unique way--not necessarily as you would react.

B. Factors which may affect responses of family members.

1. Individual personalities.

2. Situation of death.

3. Meaning child had to individual.

4. Individual characteristics of marriage relationship.

5. Cultural background.

C. Types of reactions.

1. Bereavement.

a. Must understand that grief is a natural process experienced when loved one dies.

b. Grief is related to the manner of death.

1) Illness allows time to prepare for the death.

2) Sudden, unexpected deaths often result in a more intense and disruptive grief.

2. Guilt.

   a. Common reaction in SIDS families.

   b. May be overwhelming, thus aggravating the normal grief process.

   c. Sources of guilt.

      1) Self-accusations.

         a) "I killed my baby."

         b) What parents might have done or failed to do to prevent death.

      2) Others blame parents.

         a) Other family members.

         b) First responder--must never make assumptions or accusations.

   d. May transfer to first responder--e.g., "If they had only arrived sooner, my baby would be alive."

3. Extremes.

   a. Most difficult to deal with.

      1) First responders tend to retaliate.

      2) First responders tend to ignore parents.

   b. Hysteria.

      1) Crying and wailing.

      2) Physically acting out.

   c. Anger.

      1) Verbal or nonverbal.

      2) Directed toward others--may result in abuse aimed at responder.

         a) Swearing.

         b) Name calling.

         c) "You don't know what you're doing."

d. Frustration--physically acted out.

1) Throwing things.

2) Hitting things.

III. How to deal with SIDS survivors.

A. Be in command of your own feelings and behavior at all times.

B. Act in a calm, efficient manner.

C. Exhibit kind concern.

D. Take command of the situation.

E. Protect the family from any further stress.

IV. Obtaining information.

A. Observe scene of SIDS incident.

1. Toys or foreign objects in crib?

2. Medications involved? - especially adult.

3. Position of child in crib - may account for marks on infant.

4. General appearance of scene.

B. Parents.

1. Encourage parents to talk.

2. Pay attention to the information they volunteer - much of the vital information will be naturally forthcoming.

C. Direct Questioning.

1. Offer to postpone questioning.

2. Do not:

a. Ask leading questions.

b. Ask suspicious questions.

c. Show that you doubt their capabilities as parents. (e.g., "Did you drop your baby?")

3. Ask about:

   a. What happened?

   b. Who found baby?

   c. Who else was in the house.

   d. Notice anything unusual in child's room.

   e. Any sign of illness?

   f. Medical history of infant*

V. Treatment of SIDS family at hospital emergency room.

   A. Keep parents informed about child's status, what is being done, etc.

   B. Offer sympathy and compassion.

      1. "Anything I can do?"

      2. Offer to:

         a. Make phone calls.

         b. Get some coffee for parents.

      3. Sympathetic ear--Listen!

   C. All medical information (pronouncement of death) must come from the physician.

*EMTs may need to obtain this early to help determine course of treatment.

APPENDIX E

List of Fiscal Year 1978
SIDS Information and Counseling Projects

(Listed in alphabetical order according to State)

Alabama SIDS Information and Counseling Project
248 Cox Street
Mobile, Alabama 36604
Telephone: 205 690-8101
Project Director: Alfred R. Stumpe, M.D.
Project Medical Director: Beverly Boyd, M.D.
Director of Public Health Nurses: Joy Rolinson, R.N. - 205 690-8130
Area Served: Choctau, Clarke, Coneceih, Baldwin, Mobile, Monroe, Washington, Escombia Counties

Arkansas SIDS Project
Arkansas Department of Health
Maternal and Child Health Division
4815 West Markham
Little Rock, Arkansas 72201
Telephone: 501 661-2242
Project Director: J.B. Norton, M.D. - 501 372-1510
Project Coordinator: Janis Watson, R.N. - 501 661-2233
Area Served: State of Arkansas

California SIDS Information and Counseling Project
California State Department of Health
Maternal and Child Health Section
2151 Berkeley Way
Berkeley, California 94704
Telephone: 415 843-7900 Ext. 367
Project Director: Warren Hawes, M.D.
Nursing Consultant: Carol Cook, R.N.
Area Served: State of California

Colorado SIDS Information and Counseling Center
The Children's Hospital
1056 E. 19th Avenue
Denver, Colorado 80218
Telephone: 303 861-8888 Ext. 2381
Project Director: Marie Swigert - 303 320-8333 Ext. 6201
Project Coordinator: Susan Perron, R.N. - 303 861-8888 Ext. 2381
Area Served: State of Colorado

Connecticut Management Program for SIDS
Connecticut State Department of Health
Maternal and Child Health
79 Elm Street
Hartford, Connecticut 06115
Telephone: 203 566-2279
Project Director: Carol Christoffers, R.N.
Area Served: State of Connecticut

Florida SIDS Information and Counseling Project
State Department of Health and Rehabilitation Services
1323 Winewood Blvd.
Tallahassee, Florida 32301
Telephone: 904 488-2834
Project Director: Emily Gates, M.D.
Project Coordinator: J. Robert Griffin - 904 487-1502
Area Served: State of Florida

Illinois SIDS Information and Counseling Project
Illinois Department of Health
Division of Family Services
535 West Jefferson
Springfield, Illinois 62761
Telephone: 217 782-2736
Project Director: Nancy Reinning (Acting)
Health Educator: Nancy Reinning - 217 785-2060
Area Served: State of Illinois excluding counties in the SIDS Regional Center (Loyola project)

SIDS Regional Center
Loyola University Medical Center
Building 54, 2nd Floor
2160 South 1st Avenue
Maywood, Illinois 60153
Telephone: 312 531-3420
Project Director: Lewis E. Gibson, M.D. - 312 531-3373
Project Coordinator: Milda Dargis
Area Served: Cook Lake, Illinois, McHenry, Kane, Will, Boone, Winnebago, Dupage, Dekalb and Lake City Counties

Iowa SIDS Program
Lucas State Office Building
Department of Health
Des Moines, Iowa 50310
Telephone: 515 281-4904
Project Director: Roger Chapman
Public Health Educator: Monica Eischen
Area Served: State of Iowa

Kentucky SIDS Information and Counseling Project
Kentucky State Department of Health
Department for Human Resources
Growth and Development Branch
275 East Main Street
Frankfort, Kentucky 40601
Telephone: 502 564-3527
Project Director: Patricia Nicol, M.D.
State Coordinator: Rosemary Catlett, R.N.
Area Served: State of Kentucky

Maryland SIDS Information and Counseling Project
10 South Pine Street
Baltimore, Maryland 21201
Telephone: 301 528-5062
Project Director: Stanford B. Friedman, M.D.
301 528-3542 and 528-7976
Project Administrator: Stanley Weinstein, MSW
301 528-5062
Area Served: State of Maryland

Massachusetts Regional Center for SIDS
Boston City Hospital
Department of Pediatrics
818 Harrison Avenue
Boston, Massachusetts 02118
Telephone: 617 424-5875
Project Director: Robert Reece, M.D.
Nursing Coordinator: Jill McAnulty, R.N. 617 424-5742
Area Served: State of Massachusetts

Michigan SIDS Information and Counseling Project
P.O. Box 36685
Grosse Point, Michigan 48236
Telephone: 313 963-1528
Project Director: Werner Spitz, M.D.
Project Coordinator: Zoe Smialek, R.N. 313 963-0595
Area Served: State of Michigan

The Minnesota SIDS Project
Children's Health Center and Hospital
2525 Chicago Avenue South
Minneapolis, Minnesota 55404
Telephone: 612 874-6285
Project Director: Ralph Franciosi, M.D.
Project Coordinator: Kathleen Fernback
Area Served: State of Minnesota

St. Louis SIDS Project
725 University Club Building
St. Louis, Missouri 63103
Telephone: 314 454-2141
Project Directors: Laura Hillman, M.D. - George Gantner, M.D.
314 727-6300 Ext. 319
Service Coordinator: Helen Fuller - 314 531-4100
State Coordinator: Audrey Jenkins, R.N.
Bureau of Maternal and Child Health
Broadway and State Office Bldg.
Jefferson City, Missouri 65101 314 751-4667
Area Served: State of Missouri

Nebraska Department of Health
Division of Maternal and Child Health
301 Centennial Mall S.
P.O. Box 95007
Lincoln, Nebraska 68509
Telephone: 402 471-2907
Project Director: Robert S. Grant, M.D.
Area Served: State of Nebraska

New Hampshire SIDS Management Program
New Hampshire Division of Public Health Services
Bureau of Maternal and Child Health
6 South Spring Street
Concord, New Hampshire 03301
Telephone: 603 271-2492
Project Director: Samuel W. Dooley, M.D.
Project Coordinator: Charles Alband
Area Served: State of New Hampshire

New Jersey SIDS Program
New Jersey State Department of Health
Maternal and Child Health Program
Jason Fitch Plaza, Box 1540
Trenton, New Jersey 08625
Telephone: 609 292-5616
Project Director: Margaret Gregory, M.D.
Project Coordinator: Patricia Dorsa, MSW - 609 292-7837
Area Served: State of New Jersey

New Mexico SIDS Information and Counseling Project
University of New Mexico, School of Medicine
Office of the Medical Examiner
Albuquerque, New Mexico 87131
Telephone: 505 277-3053
Project Director: James T. Weston, M.D.
Project Coordinator: Beverly White, R.N.
Area Served: State of New Mexico

New York City Information and Counseling Program
Office of Medical Examiner
520 First Avenue, Room 506
New York, New York 10016
Telephone: 212 686-8854
Project Co-Directors: Jean Pakter, M.D.
Director of Maternity and Family Planning
Department of Health 212 566-7076
Michael M. Baden, M.D., Chief Medical Examiner
212 684-1600
Project Coordinator: Christine Blenninger
Area Served: New York City

New York Genesee Region SIDS Information and Counseling Center
224 Alexander Street
Rochester, New York 14607
Telephone: 716 263-6015
Project Co-Directors: Margaret Colgan, M.D.
Robert Hoekelman, M.D.
Project Coordinator: Jacke Rheingold - 716 263-6017
Area Served: Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, and Yates Counties

New York SIDS Information and Counseling Project
Health Sciences Center, Room 119, Level 3
Stonybrook, New York 11794
Telephone: 516 444-2582
Project Director: Sanford Kravitz, Ph.D. - 516 444-2139
Project Associate Director: Elizabeth Jean Scully, MSW - 516 444-2582
Area Served: Suffolk and Haussau Counties

North Carolina SIDS Information and Counseling Project
Department of Human Resources
P.O. Box 2091
Raleigh, North Carolina 27602
Telephone: 919 733-7791
Project Director: Jimmie Rhyne, M.D.
Project Coordinator: Henrietta Fullard, R.N.
Area Served: State of North Carolina

A Program for SIDS in Ohio
Bureau of Maternal and Child Health
246 North High Street
Columbus, Ohio 43216
Telephone: 614 466-2253
Project Director: John H. Ackerman, M.D.
Project Coordinator: Marsha Herring - 614 466-8804
Area Served: State of Ohio

Pennsylvania SIDS Resource Center
Children's Hospital of Philadelphia
One Children's Center
Philadelphia, Pennsylvania 19104
Telephone: 215 472-2229
Project Director: George Peckham, M.D.
Project Coordinator: Micheal D'Antonio, Ph.D.
Area Served: State of Pennsylvania

Rhode Island SIDS Information and Counseling Project
Rhode Island Department of Health
Division of Child Health
75 Davis Street, Room 302
Providence, Rhode Island 02908
Telephone: 401 277-2309
Project Director: J.E. Cannon, M.D. 401 277-2231
Project Coordinator: Marie Almagno, R.N.
Area Served: State of Rhode Island

South Dakota SIDS Project
Sioux Valley Hospital
1100 South Euclid Avenue
Sioux Falls, South Dakota 57105
Telephone: 605 339-6578
Project Director: Stanley Graven, M.D.
Project Coordinator: Debra Swope, MSW (Acting)
Area Served: State of South Dakota

SIDS Information and Counseling Project
in the North Texas Area
South West Institute of Forensic Sciences
5230 Medical Center Drive
Dallas, Texas 75235
Telephone: 214 638-1131
Project Director: Arthur Weinberg, M.D.
Project Coordinator: Tony Wilcox
Area Served: 93 counties of Northern Texas

SIDS Information and Counseling Project
Harris County Health Department
2370 Rice Boulevard
P. O. Box 25249
Houston, Texas 77005
Telephone: 713 526-8448
Project Director: Francine Jensen, M.D.
Project Coordinator: Rita La Grande
Project Area: Harris, Houston, Galveston, Montgomery, Matagoia, Colorado, Austin, Wharlan, Walker, Liberty, Broziora, Ft. Bend, Chambers, and Waller Counties

SIDS Information and Counseling Project
Utah State Division of Health
Family Services Branch
44 Medical Drive
Salt Lake City, Utah 84113
Telephone: 801 533-6161
Project Director: Peter Van Dyck, M.D.
Social Work Consultant: Roberta M. Mahin, MSW
Nursing Consultant: Echomae Anderson, R.N.
Area Served: State of Utah

Information and Counseling for SIDS
Vermont Department of Health
115 Colchester Avenue
Burlington, Vermont 05401
Telephone: 802 862-5701 Ext. 311
Project Director: Roberta C. Coffin, M.D. 802 862-5701 Ext. 365
Project Coordinator: Cheryl Cyr, R.N.
Area Served: State of Vermont

SIDS Northwest Regional Center
4800 Sand Point Way, NE
Seattle, Washington 98105
Telephone: 206 634-5323
Project Director: Nora Davis, M.D.
Project Coordinator: Irene Wiley, R.N.
Area Served: State of Washington

Inland Empire Regional Center for SIDS
Information and Counseling
West 1115 Mallon Avenue
Spokane, Washington 99201
Telephone: 509 456-3630
Project Director: F. Lee Mellish, M.D.
Project Coordinator: Merilyn Lloyd, R.N.
Area Served: 17 Counties of Eastern Washington
10 Counties of Northern Idaho
8 Counties of Western Montana

Wisconsin SIDS Information and Counseling Project
Wisconsin Department of Health and Social Services
Division of Health
P.O. Box 309
Madison, Wisconsin 53701
Telephone: 608 266-2661
Project Director: William Schatz
Project Coordinator: Mary Beckham, R.N. (Acting)
Area Served: State of Wisconsin

APPENDIX F

Bibliography

BIBLIOGRAPHY

The bibliography is organized in two sections: Printed Materials and Audiovisual Materials. Articles, brochures, pamphlets, and other printed sources, including course outlines and syllabi, are listed in the Printed Materials section. Films, slides, videotapes, and other non-print media are cataloged in the Audiovisual Materials section. Each group includes an annotation. In addition, an acquisition source (AS) is given for those entries not readily available through a library. Prices quoted in this bibliography are as of September 1978, and are subject to change.

Printed Materials

Author. SIDS: The officer's role. Arkansas SIDS Information and Counseling Project, 1978.

Presents the police officer's situation upon entering a home where a possible sudden infant death or child abuse incident has occurred.
AS: Arkansas Department of Health, SIDS Project Administrator, Division of Maternal and Child Health, 4815 West Markham Street, Little Rock, Arkansas 72201

Author. Syllabus. Arkansas SIDS Information and Counseling Project, 1978.

Includes a lesson plan, pre- and post-test and evaluation form for a 30-45 minute presentation.
AS: Arkansas Department of Health, SIDS Project Administrator, Division of Maternal and Child Health, 4815 West Markham Street, Little Rock, Arkansas 72201

Barocas, H. and Katz, M.L. Dayton's pilot training program: Crisis intervention. The Police Chief. July 1971.

Although not specifically related to SIDS, the role playing discussion promotes insight into possibilities of using the technique in a SIDS training situation.

Beckwith, J. Bruce, M.D. The Sudden Infant Death Syndrome. (HSA) 76-5137 DHEW, Health Services Administration, 1976. 34 pp.

Presents a general review of the problem and the results of a research study on over 500 post-mortem examination findings on cases of SIDS. Topics included are: Epidemiology, Pathologic Findings, Theories of Causation, "Near Misses," and Counseling.
AS: Program Services Branch, Bureau of Community Health Services, Room 7-A-20, 5600 Fishers Lane, Rockville, Maryland 20857 or Government Printing Office, Superintendent of Documents, Washington, DC 20402

Bergman, A.B. Editorial: SIDS: Current status of the problem. Southern Medical Journal. 69(1) January 1976. pp. 1-3.

Gives the characteristics of SIDS, the status of ongoing research, and the emotional reactions of parents.

Bergman, A.B., Pomeroy, M.A., and Beckwith, J.B. The psychiatric toll of the sudden infant death syndrome. General Practitioner. (4) December 1969. pp. 99-105.

Typical parental reactions and their difficulties in coping with a sudden infant death are presented.

Author. Training key 162: Interpersonal communications. Bureau of Operations and Research of the International Association of Chiefs of Police, 1971.

Brief introduction into interpersonal communication theories.
AS: International Association of Chiefs of Police, 11 Firstfield Road, Gaithersburg, Maryland 20760

Author. Training key 208: Sudden infant death syndrome. Bureau of Operations and Research of the International Association of Chiefs of Police, 1974.

Information is directed towards the police community. Fold-out pamphlet describing SIDS, the initial response of the police officer, interviewing the parents, and the autopsy. A Discussion Guide is also included. This is presently being updated.
AS: International Association of Chiefs of Police, 11 Firstfield Road, Gaithersburg, Maryland 20760

Author. Training key 209: Crisis intervention. Bureau of Operations and Research of the International Association of Chiefs of Police, 1974.

Discussion of the courses of action available to the law enforcement community.
AS: International Association of Chiefs of Police, 11 Firstfield Road, Gaithersburg, Maryland 20760

Author. Educational program for beginning police officers. Central Maryland SIDS Information and Counseling Project, 1978.

Includes objectives, pre- and post-test, a four-page lesson plan, a two-page fact sheet, and an evaluation form.

Cheatham, R.T. and Erickson, K.V. Police communication instruction: Pedagogical strategies. Speech Teacher. 24(2) March 1975. pp. 165-168.

Suggests a curriculum which includes exercises in audience analysis, interviewing, simulation, role playing, and small group discussion.

Author. Guidelines for intervention--hospital emergency room. (Attachment 10 to Annual Report 7-1-76 to 6-30-77.) Connecticut SIDS Information and Counseling Project, 1978.

Attitudes and actions of emergency room personnel as they relate to parents of a sudden infant death.
AS: State of Connecticut Department of Health, C/O SIDS Project Coordinator/Director, 79 Elm Street, Hartford, Connecticut 06115

Daniels, J. Our baby is dead. Training. 12(4) April 1975. pp. 42-43.

Content on SIDS police training course.

Author. Syllabus. Pennsylvania SIDS Information and Counseling Project, 1978.

Includes an outline for a 2-1/2 hour presentation, a three-page content outline, an evaluation form, a two-page handout for police officers, and a list of slides comparing child abuse and SIDS infants.
AS: Program Coordinator, Pennsylvania SIDS Community Resource Center, Children's Hospital of Philadelphia, One Children's Center, Philadelphia, Pennsylvania 19104.

Author. Death investigation: An analysis of laws and policies of the United States, each state, and jurisdiction. (HSA) 78-5252 Department of Health, Education, and Welfare, Health Services Administration. January 1977.

Information on medico-legal death investigations with particular attention to SIDS.
AS: Government Printing Office, Superintendent of Documents, Washington, DC 20402

Author. Facts about sudden infant death syndrome. HSA: 78-5259 Department of Health, Education, and Welfare, Health Services Administration. 11 pp.

Facts and frequently asked questions with answers. Also discussion of grief and sources of help and information.
AS: Program Services Branch, Bureau of Community Health Services, Room 7-A-20, 5600 Fishers Lane, Rockville, Maryland 20857 or Government Printing Office, Superintendent of Documents, Washington, DC 20402

Author. Los Hechos Sobre el Sindrome de la Muerte Infantil Repentina HSA: 78-5254 Department of Health, Education, and Welfare, Health Services Administration. 13 pp.

A pamphlet for Spanish speaking people on the facts and answers to frequently asked questions concerning SIDS. Also includes a discussion of grief and sources of help and information. (NOTE: Identical in content to (HSA) 78-5259.)
AS: Program Services Branch, Bureau of Community Health Services, Room 7-A-20, 5600 Fishers Lane, Rockville, Maryland 20857 or Government Printing Office, Superintendent of Documents, Washington, DC 20402

Duke, P. Media on death and dying. OMEGA: Journal of death and dying. 6(3) 1975. pp. 275-287.

Annotated list of films, tapes, and other instructional materials appropriate for death education courses.

Author. SIDS training package for police standards and training commission. Florida SIDS Information and Counseling Project, 1978.

Includes a SIDS learning design, a five-page lesson plan, suggested exam questions, and a one-page handout. No more than five copies of the package per request.
AS: SIDS Project Coordinator, Suite 261, Taylor Building, Koger Executive Center, 2574 Seagate Drive, Tallahassee, Florida 32301

Author. SIDS and the law enforcement officer: Instructional block. Genesee Region SIDS Information and Counseling Project, 1978.

One-page outline of course content and objectives for a one-hour training session. Single copy only, available upon request.
AS: SIDS Project Coordinator, Genesee Hospital, University of Rochester, School of Medicine and Dentistry, 224 Alexander Street, Rochester, New York 14607

Green, J. Killer disease: SIDS. Nursing Care. April 1975. pp. 19-20.

Introductory information on SIDS.

Author. EMS training outline and program. Illinois SIDS Information and Counseling Project, 1978.

Includes three-page outline, seven-page program guide, two-page fact sheet for police officers and listing of suggested readings for first responders. Limit: 50 copies per request.
AS: SIDS Project Health Coordinator, Illinois Department of Public Health, 535 West Jefferson Street, Springfield, Illinois 62761

Author. First responder articles. Illinois SIDS Regional Center, 1977.

Two articles are available concerning SIDS and first responders--one especially of EMTs and one for police officers. Both articles are brief.
AS: SIDS Regional Center, Loyola University, Medical Center, 2160 South First Avenue, Maywood, Illinois 60153

Klemsrud, J. Tragedy with an aftermath of guilt. New York Times. June 19, 1972 issue.

Describes the long-term personal experiences of the parents of a sudden infant death, including their recollections of how the police reacted at the scene. Activities of National SIDS Foundation are also described.
AS: National SIDS Foundation, 310 South Michigan Avenue, Chicago, Illinois 60604

Le Blanc, R.D. Somebody help my baby. Good Housekeeping. July 1973. pp. 16-26.

Reactions of parents to a sudden infant death.

Lefkowitz, J. Job attitudes of police: Overall description and demographic correlates. Journal of Vocational Behavior. 5(2) October 1974. pp. 221-230.

Questionnaire data from 312 policemen in midwest city.

Author. Orientation outline for EMS recruits. Michigan SIDS Information and Counseling Project, 1978.

One-page outline providing content areas and a time frame breakdown.
AS: Michigan Regional SIDS Center, 400 East Lafayette, Detroit, Michigan 48226

Miles, M.S. SIDS: Parents are the patient. Journal of Emergency Nursing. 3(2) March-April 1977. pp. 29-32.

Parental reactions to a sudden infant death.

Nakushian, J.M. The other victims of SIDS. Journal of Emergency Nursing. 2(3) May-June 1976. pp. 15-16.

Family reactions to a sudden infant death.

Author. Facts about sudden infant death syndrome. National SIDS Foundation.

Brochure on SIDS giving general information such as definition, incidence, and problems of grief. (NOTE: This is similar to DHEW Brochure HSA 78-5259 listed on Page F-4.) Price $10/100 copies. Less than 100 copies, 15 cents each.
AS: National SIDS Foundation, 310 South Michigan Avenue, Chicago, Illinois 60604

Author. Facts about sudden infant death syndrome for police officers. National SIDS Foundation.

Brochure focuses on SIDS information which is vital for the police officer. Price $4/100 copies. Less than 100 copies, 5 cents each. AS: National SIDS Foundation, 310 South Michigan Avenue, Chicago, Illinois 60604

Author. Syllabus. New Mexico SIDS Information and Counseling Project, 1978.

Includes symposium objectives, seven-page course outline, and a four-hour program timetable.
AS: SIDS Project, University of New Mexico, School of Medicine, Office of Medical Investigator, Albuquerque, New Mexico 87131

Parker, G.M. Human relations training: Improving police/community relations. Training and Development Journal. 28(10) October 1974. pp. 7-12.

Presentation on human relations skills training sessions.

Author. SIDS: The emergency responder. St. Louis SIDS Information and Counseling Project, 1978.

One-page brochure explaining what a sudden infant death is and how the first responder can help. Up to 10 copies available free of charge. Printing fee charged on requests for 11 or more copies. AS: St Louis SIDS Project, St. Louis Regional Maternal and Child Health Council, 607 North Grand Avenue, #724, St. Louis, Missouri 63103

Samburg, M. SIDS: A parent's experiences. Nurse News. 50(10) June 1977. pp. 1-2.

Parental reactions to a sudden infant death.

Taylor, J.R. Meeting the many problems of an unexpected infant death. Michigan Medicine. 75(4) April 1976. pp. 205-207.

Discusses the implications for the parents and the importance of obtaining the correct cause of death through autopsy.

Weinstein, S.E. SIDS: The role of the EMT. Emergency Product News. September 1974.

Presents the skills and knowledges needed by an EMT to handle a SIDS incident.

White, B.C. Grief, some general considerations. Office of the Medical Investigator Newsletter--New Mexico. IV(4) April-May-June 1977.

Presents symptoms, stages, and types of grief experienced by parents of a sudden infant death.
AS: New Mexico SIDS Information and Counseling Project, University of New Mexico, School of Medicine, Office of Medical Investigator, Albuquerque, New Mexico 87131

Williams, W.V. et al Crisis intervention: Effects of crisis intervention on family survivors of SIDS. Community Mental Health Journal. 12 Summer 1976. pp. 128-136.

Discusses crisis intervention as it applies to the particular situation faced by the family of sudden infant death.

Audiovisual Materials

A Call for Help. Department of Health, Education, and Welfare, Health Services Administration. 1975. 16mm motion picture.

Motion picture to help emergency workers and first responders understand and help the families of a sudden infant death.
19 minutes, sound, color. No-charge bookings are made through: National Medical Audiovisual Center, Annex, Station K, Attention: Film Distribution, Atlanta, GA 30324. Purchase price: $110.25. Allow 6 weeks when ordering.
AS: Order Branch, National Audiovisual Center, (GSA) Washington, DC 20409

After Our Baby Died. Department of Health, Education, and Welfare, Health Services Administration. 1975. 16mm motion picture.

The purpose of this film is to increase awareness of the trauma and suffering experienced by parents of SIDS babies and to underline the importance of effective parent counseling by the health professionals. Instructor's Guide for the film is also available. To be used by health personnel. Not available for showing to general audiences. No-charge bookings are made through: National Medical Audiovisual Center, Annex, Station K, Attention: Film Distribution, Atlanta, GA 30324. Purchase price: $116. Allow 6 weeks when ordering.
AS: Order Branch, National Audiovisual Center, (GSA) Washington, DC 20409

Crib Death. University of Minnesota, Center for Death Education and Research. 1972. 2-track monaural sound cassette with guide.

Documentary on SIDS for health services personnel. One of a package of six cassettes entitled Death and the Child. Price: $15/each. Complete package price: $90.
AS: Robert J. Brady Company, Routes 450 & 197, Bowie, Maryland 20715

Crib Death or Sudden Infant Death Syndrome. Georgia Regional Medical Group. Videotape.

Barbara Bruner, M.D., Chairman of Georgia National SIDS Foundation Chapter, discusses the 10,000-15,000 babies that die of SIDS each year. 47 minutes, black and white.
AS: Georgia Regional Medical Group, PO Box 26121, Atlanta, GA 30303

Death Notification. Harper & Row. 1977. 16mm motion picture.

Presents effective techniques to use in a variety of death notification situations. 22 minutes, color, sound. Purchase price: $365. Rental fee: $50/one week.
AS: Media Department, Harper & Row, Publishers, 10 East 53rd Street, New York, New York 10036

Interview with Dr. Bergman. Denver Police Department. Videotape cassette. 23 minutes, color.

An expert in the area of SIDS talks about the policeman's role in a sudden infant death situation and a child abuse situation.
AS: Denver Police Department, Denver, Colorado 80200

SIDS: Challenge to Police Officers. Kristin Boyer. Pennsylvania SIDS Information and Counseling Project. 1977. Videotape on 3/4" cassette.

Defines police involvement in a child abuse/sudden infant death situation. Contains six parts: 1) Facts abouts SIDS, 2) Characteristics of SIDS victims, 3) SIDS is not child abuse, 4) The distress call, 5) "Your baby is dead," and 6) Meeting the challenge of SIDS. Approximately 15 minutes. Purchase price: $60 to SIDS Projects; $120 to all others. No-charge rental within Pennsylvania only.
AS: Program Coordinator, Pennsylvania SIDS Information and Counseling Project, Children's Hospital of Philadelphia, One Children's Center, Philadelphia, Pennsylvania 19104

SIDS: Not Child Abuse. Carolyn Schodt. Pennsylvania SIDS Information and Counseling Project. 1978. 35mm slide set.

Compares child abuse victims with victims of the sudden infant death syndrome. Purchase price: $25. Rental fee: No charge. AS: Program Coordinator, Pennsylvania SIDS Information and Counseling Project, Children's Hospital of Philadelphia, One Children's Center, Philadelphia, Pennsylvania 19104

Sudden Infant Death Syndrome. Genesee Regional SIDS Information and Counseling Project/SUNY Agricultural & Technology College of Alfred, New York. 1976. Videotape on 3/4" cassette.

Presents basic facts on sudden infant death, on the needs and reactions of parents, and on the grieving process. Includes general resources that are available. Can be used as an introduction or summary. Not directed toward any one audience. If interested in renting, call (716) 263-6015. Availability limited.

You Are Not Alone. Department of Health, Education, and Welfare, Health Services Administration. 1976. 16mm motion picture, 27 minutes, color, sound.

A motion picture to help health professionals and volunteer groups in the counseling of families affected by SIDS. No-charge bookings are made through: National Medical Audiovisual Center, Annex, Station K, Attention: Film Distribution, Atlanta, GA 30324. Purchase price: $156.50.
AS: Order Branch, National Audiovisual Center, (GSA) Washington, DC 20409